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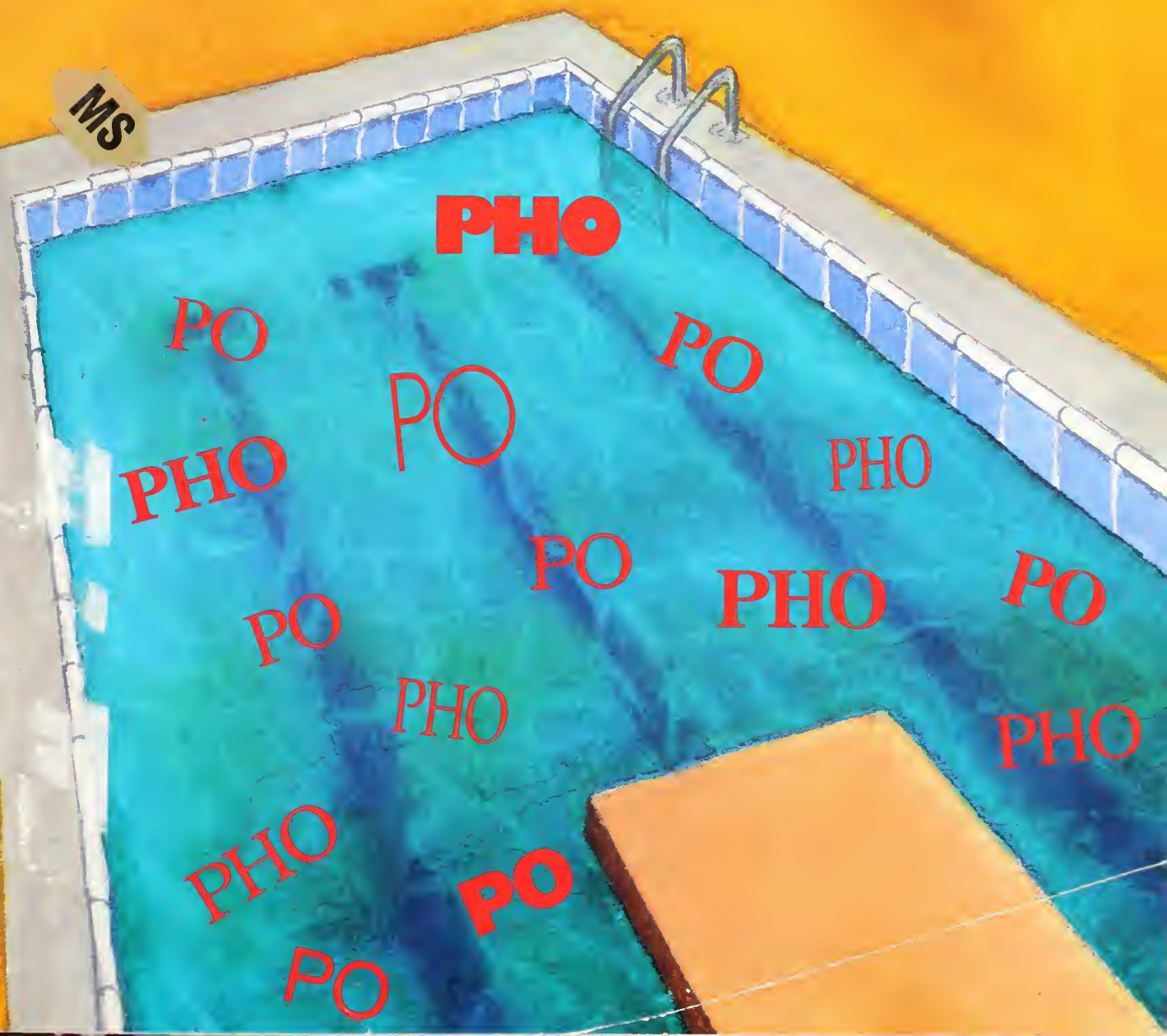
INDIANA MEDICINE

The Journal of the Indiana State Medical Association

January/February 1994

Vol. 87, No. 1

PHOs & POs: Should you take the plunge?





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INDIANA MEDICINE

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features

Managed competition architect explains blueprint12

INDIANA MEDICINE interviews Lynn Etheredge, one of the architects of the managed competition idea adopted by President Clinton for his health care reform proposal.

PHOs and POs: Should you take the plunge?18

Physician-hospital organizations and physician organizations are gaining attention across the country as physicians try to prepare for health system reform.

How can you defer mutual fund taxable income and gains?24

While many mutual fund track records are impressive, physicians must look at the after-tax returns of the funds, especially in light of the new higher tax brackets.

Marble-ous hobby fascinates collector26

An Indianapolis family practice physician appreciates the craftsmanship and beauty of objects once considered only childhood toys.

1993 ISMA convention highlights28

1993 ISMA convention coverage34

ISMA Fifty Year Club66

scientific contribution

Endoscopic screening for colorectal cancer: Recent studies from Indiana University68



Cover story begins on page 18.
Cover design by Diane Alfonso
of Indianapolis.

departments

stethoscope	4
letters to editor	6
editorial	8
annual reports	44
resolutions	47
isma leadership	67
alliance report	88
from the museum	90
cme calendar	92
news briefs	94
obituaries	96
people	98
classifieds	102

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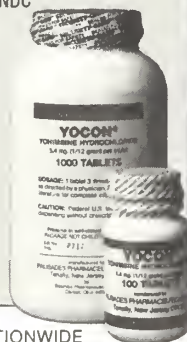
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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
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ISMA cancels legislative reception after theme criticized

The Indiana State Medical Association was criticized last month for its legislative reception's theme and promotional materials. In response, the annual legislative reception, which was to have been Jan. 12, was canceled, and the ISMA has issued a public apology to all persons who were offended by the invitation and the theme.

The ISMA staff, which was solely responsible for the design of the event, acknowledged that the invitation and theme lacked an awareness and sensitivity to African-Americans. In issuing the apology, the ISMA said, "It was never our intention to offend anyone. Nor should this incident be construed, in any way, to be indicative of the ISMA's opinion of minority citizens. If there is a lesson to be learned from this unfortunate incident, it is that we all need to be more aware."

Dues to lobbying groups no longer fully deductible

As a result of President Clinton's Revenue Reconciliation Act of 1993, dues paid to associations that carry out lobbying activities may no longer be fully deductible. The ISMA has notified its members of the non-deductible portion of state dues by declaring the portion of dues allocable to lobbying expenditures on the back of the new membership card. The AMA, in a similar action, will notify its members of the non-deductible portion of dues in the guide to member benefits. Non-deductible county and district dues will vary by location.

Brochures answer questions about Clinton health system reform

The ISMA has developed a brochure explaining health system reform called "How Will the Clinton Health Reform Proposal Affect You and Your Family?" for physicians to distribute to their patients.

The brochure provides answers to the following questions:

- Will I still be able to see my own doctor?
- Will my premiums, deductibles and copayments go up?
- What if someone in my family has a preexisting health condition?
- Will Medicare coverage be affected?
- Will costs be controlled in a way that doesn't interfere with my medical care?

A sample of the brochure was mailed with the January issue of *ISMA Reports*. The brochures are \$15 per 100 copies, including shipping and handling. To order, call Toni Settle at the ISMA, (317) 261-2060 or 1-800-257-4762.

"Dear Patient" letter explains concerns about health reform

A copy of a "Dear Patient" letter on health system reform that was mailed with the January issue of *ISMA Reports* explains physician concerns about some of the health system reform proposals now being considered. The letter is designed for physicians to sign, photocopy and distribute to their patients. Areas of physician concern include quality of care, choice, universal coverage and red tape. ▮



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■ letters to editor

Editor's note: Rep. Paul Mannweiler, R-Indianapolis, sent the following letter to a group of Indiana physicians in October 1993. In response, Rep. Mike Phillips, D-Boonville, issued a letter, also printed below. The letters are published here only as informational items for ISMA members.

The Democrats are attacking our health care system at every opportunity, and while modest changes may be necessary, the Democrats have proposed radical and damaging overhauls. It's happening at both the state and national levels of government. Unfortunately, under the shadow of the national debate, few people have recognized the devastating proposals being made right here in Indiana.

Indiana Democrats in the state legislature have been pushing outlandish legislation that, if not stopped, will destroy health care as we know it. And they will continue this fight until they have completely socialized health care.

In the past session, Democrats tried to ram through universal health care for Indiana, a concept that seems noble on the surface but on further examination shows a very different reality. As you certainly know, nearly every government that uses this system is bankrupting itself and has seriously undermined its ability to provide quality or even adequate care.

The fact is such a system would create a huge new state bureaucracy (the Indiana Health Insurance Commission) that you, the doctor, would have to answer to. Government bureaucrats would dictate for whom, how or even if you would provide health

care. Moreover, it would cost a fortune; preliminary estimates were between \$18 billion and \$22 billion and expected to grow significantly. That would have nearly doubled our entire state budget!

The Democrats also proposed highly punitive legislation affecting doctors and hospitals. This included the Medicaid Provider Network proposal that, if passed, would actually have taxed hospitals and limited physicians' ability to make health care decisions. This legislation would have driven small and rural hospitals out of business and, ultimately, encouraged doctors to leave Indiana.

Fortunately, these proposals and many others like them were stopped by Indiana Republicans. You see, to the great credit of Indiana doctors and other health care providers, Indiana has one of the best health care systems in the world. We have innovative research, state-of-the-art facilities and, unlike many states, a broad base of primary care physicians.

Nonetheless, the Democrats continue using scare tactics to create a "crisis" atmosphere – encouraging emotional solutions to a problem that requires rational thought. It's ironic: The health care system on which our very lives depend is being meddled with by people who have no real knowledge of how the system works.

That's why it is absolutely vital that under the shadow of the national health care debate we don't lose sight of what's happening right here in Indiana. I'd like you to help stop this anti-physician trend by helping to elect Republicans to the Indiana House of Representatives.

As Republicans, we will prevent further Democrat tampering with our health care system and stop the assault on the medical profession, but we must have your help. I need you to make a contribution of \$1,500, \$1,000, \$500 or whatever amount you can afford, to the House Republican Campaign Committee today.

We must go into 1994 fully prepared for whatever the Democrats throw at us. Your gift will help us to do that. By contributing to the HRCC today, you'll be supporting candidate recruitment, voter identification programs, coalition building, media advertising and other programs that directly support Republican House candidates.

You see, if we are unable to elect a Republican majority to the Statehouse, our health care system will continue to be assaulted by Democrats who fail to understand the negative effects of their mandated health program. □

Rep. Paul S. Mannweiler
Republican leader
108th Indiana General Assembly

This is NOT a fundraising appeal.

I begin with this disclaimer because recently a doctor constituent of mine shared with me her letter from the House Republican Campaign Committee authored by Rep. Paul Mannweiler.

I immediately recognized the format as the typical letter designed to tap the pocketbooks of Indiana medical providers, not unlike Rep. Mannweiler's letter in the last election cycle that declared that the Democrats were hell-bent on destroying Indiana's

■ letters to editor

Medical Malpractice System (despite the fact that our malpractice law was authored by a Democrat, Speaker Protem Chet Dobis).

As I read on, what amazed me was the utter cynicism of the "pitch" this time. In a letter loaded with scare tactics designed to create a "crisis" atmosphere and squeeze you for a contribution, Rep. Mannweiler declared the Democrats were "using scare tactics to create a crisis atmosphere ... encouraging emotional responses to a problem, etc., etc. ..."

Doctors typically have nine to 12 years of postgraduate education – a higher level than any other profession in our society. Thus, it was most surprising that Rep. Mannweiler's letter was couched in terms that demean one's intelligence (i.e., "they will destroy health care as we know

it," "... they will continue this fight until they have completely socialized health care," and "it would cost a fortune ... between \$18 and \$22 billion ... would have nearly doubled our entire state budget!").

The ludicrousness of such statements hardly deserves a response. Suffice it to say that worn out slogans from the cold war era play better with a totally uninformed readership. The notion that my caucus would support "doubling the state budget" wouldn't be swallowed even by the most partisan reader. One need only ask why I would lead my caucus, even if I could, down the path of massive fiscal chaos and total defeat!

You should know that I and my caucus have a high regard for the health care professional. We are not anti-physician and will not

advance legislation that would harm the quality of health care for our constituents.

In fact, I regularly converse with your lobbyist assigned to the Statehouse and individual doctors, dentists, optometrists, nurses and other health professionals. While we may differ on a variety of nuances and sometimes on a particular bill, our differences generally are compromised agreeably. It would be most surprising if these individuals would describe me and my caucus as Rep. Mannweiler did.

Finally, I want you to know that I will not insult your intelligence by writing a simplistic letter in an attempt to squeeze a contribution. □

Rep. Michael K. Phillips
Speaker of the House
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Why physicians should support gun control

Holly Mattix
Indianapolis

Because of the advancement of medical technology and scientific research, physicians now can successfully diagnose and treat most of our society's physical ailments. We can control hypertension, detect occult tumors and transplant organs. We appear to be using every resource we have as physicians to help our fellow man, but are we? During President Clinton's health care reform speech, he reminded us of the enormous economic burden that violent crimes secondary to handguns have on the health care system. Gun control is an essential component of health care reform. Gun control could decrease the cost of health care, especially in inner cities, and it may decrease overall mortality and morbidity, most notably among adolescent males. Physicians, therefore, should support health care reform that incorporates handgun restriction and stronger law enforcement of regulations.

Politicians, doctors and insurance agencies are bucking heads deciding how and where to cut costs in the new health care system. Cigarettes will be taxed, and health care workers' paychecks will shrink, but certainly more corners need to be clipped to contain the cost of medical care. However, we will never be able to afford a new health care system if we do not attack the explosion of violence in our country due to handguns.

According to U.S. Sen. Bill Bradley (D-N.J.), about \$4 billion is spent per year on medical costs resulting from firearm injuries. More than 64% of all murders in

1990 were committed using firearms, according to the FBI uniform crime reports, and every year 23,000 Americans are killed with handguns, including suicides, homicides and accidents.¹

These statistics are not improving. In 1991, there were 1.9 million violent crimes committed in the United States, compared to 1.3 million in 1981.² If we compare the mortality in America secondary to handguns to other countries that support gun restrictions, the findings are alarming. In 1990, handguns killed 22 people in Great Britain, 13 in Sweden, 87 in Japan and 10,567 in the United States. Of the former countries, the United States is the only country that allows its citizens to bear arms for protection. We are not protecting our citizens, we are murdering them while creating medical bills that no one can afford. Health care reform must address the economic issues of handgun violence if we ever hope to create a sustainable health care system.

With more than 200 million handguns, rifles and shotguns in circulation, as reported by the Bureau of Alcohol, Tobacco and Firearms, gun restriction is a necessity. A study done by Sloan et al compared the homicide rates of British Columbia and Seattle, Wash., during the period from 1980 to 1986. Seattle had four times the number of guns and twice the homicide rate of British Columbia, showing an association between the prevalence of firearms and homicide rates.³

When handgun homicide rates of border states of the United States and adjoining provinces in Canada from 1976 to 1980 were compared, there were 43,691 murders or 2.5 homicides per

10,000 handguns in the United States and 304 murders or 2.2 homicides per 10,000 handguns in Canada. The overall prevalence of homicides was equal even though there were four to 10 times as many handguns per 1,000 population in the border states. The study, however, did not include larger metropolitan areas where handgun violence is most prevalent. When New York City and Buffalo were included, the homicide rate for New York almost tripled. In contrast, homicide rates in Canada did not increase when major metropolitan areas were included.⁴

Because there is no way to adequately predict the exact outcome of stricter gun control, many Americans oppose new legislation. Some argue that gun control will merely unarm law-abiding citizens, giving criminals an advantage. However, when Loftin et al studied the effects of handgun restrictions in the District of Columbia on suicide and homicide, they found that gun-related homicides and suicides declined to a mean of 9.7 per month after implementation of gun restrictions, compared to 13 per month before new gun control measures. Areas near the District of Columbia without handgun control did not see a decline in gun-related homicides during this same period.⁵ Such examples show that gun restrictions could only benefit our society.

Although support for gun control is at an all-time high, only 78% of the American public is in favor of waiting periods before the purchase of handguns, and less than half of the population supports a complete ban on the sale of handguns.⁶ It is unlikely that the right to purchase and

own firearms will ever be revoked in this country, but we must find a happy medium. Examples of self-defense resulting from possession of handguns are a minority compared to the homicides, suicides and accidental shootings that occur everyday in the United States.

As physicians, we directly see the effects of handguns on our society. Our influence on gun control legislation and health care reform is critical now. We need strict gun control, and there is no time to wait. I urge all physicians, medical students and other

health care workers to write to their congressional representatives and senators and urge them to support gun control legislation. Guns are not protecting our society — they are murdering our society. We need to intervene before it is too late. □

The author is a fourth-year medical student at the Indiana University School of Medicine and a member of the INDIANA MEDICINE editorial board.

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Managed competition

Bob Carlson
Indianapolis

Lynn Etheredge is one of the architects of the "managed competition" idea adopted by President Clinton for his health care reform proposal. Recently, he served as associate director for health care reform with the Clinton-Gore transition team and as a consultant to the interagency task force developing the reform plan. He has also been involved in state health policy reforms as a member of the National Governors Association health care task force and the national advisory committee for the Robert Wood Johnson Foundation's state health policy project.

Etheredge is an independent consultant who works with the public and private sectors on health care reform, income security and government policy issues. He served in the federal Office of Management and Budget during four administrations. He worked on Medicare, Medicaid and national health insurance in the 1970s and directed the professional health staff of the Office of Management and Budget in both the Carter and Reagan administrations.

He is the author of more than 40 publications, including *The Jackson Hole Initiatives for a 21st Century American Health System*, which he wrote with Paul Ellwood and Alain Enthoven. He is a graduate of Swarthmore College.

In this conversation with INDIANA MEDICINE following his participation in "The Road to Health System Reform" panel during the ISMA convention, Etheredge discusses how President Clinton's plan has diverged from the "Jackson Hole Plan." He

also shares his views on how managed competition is likely to affect the way physicians practice medicine, how primary care physicians may be affected differently than specialists, how rural areas will do compared to urban and what impact all this will have on medical education.

INDIANA MEDICINE: Does President Clinton's managed competition proposal differ from yours?

Etheredge: Yes. There are three differences: the budget, the tax code and the size of an alliance. It differs from the Jackson Hole Plan and managed competition as it's proposed by the Conservative Democratic Forum bill and the Senate Republican bill, mostly by putting a budget on the system and saying that the premiums in an area cannot exceed a certain level. [President Clinton's managed competition proposal] puts a limit on the premiums that can be charged for the plans that you and I and everyone else buy.

Our view was that the government should make sure that there is an effective market so consumers could choose among standard plans, that what people decide to buy with their own after-tax dollars should be up to them. We would not limit the amount of expenditures that could be made in an area. In other words, just like government doesn't limit what we can spend on education or cars or home or clothing, we don't think there's a role in our society for government to limit the amount that can be spent [on health care premiums]. There is a very important role for government in health care to make sure that people get the



architect explains blueprint

financing they need to buy insurance, that there are good standard choices that they can make and that they can make an informed choice from among different plans.

Now, under the Clinton plan people could always go out and buy supplemental insurance outside the system and spend their own money. So Clinton is not proposing a rationing system directly but is limiting the terms of competition in the marketplace to numbers arbitrarily set by the government. I think there are a number of concerns about this. One is that we don't think it's necessary. We think if you set up a well-functioning market, you will in fact give consumers the combination of cost, quality and service that they want and that can be delivered.

Second, I think government is just going to screw it up. This is a trillion dollar industry. This is 14% of our economy. On a stand-alone basis, health care is the eighth largest economy in the world. This is like trying to run Italy with a little board of seven people and a computer. I think the health care system is about as organized as Italy and probably about as easy to run from Washington. To really enforce this highly detailed level of regulation, I think, is pushing the limits of American government well beyond what it's capable of doing.

On the tax code, we say that employer contributions beyond the amount needed to buy a standard policy, efficiently provided, would be taxed as income to the worker. The intent of that is that if workers buy more than the basic plan, they're spending their own after-tax dollars. The Clinton

administration did not include that mostly because the labor unions were opposed because many of the very generous, expensive plans happen to be union plans. That's how they got to be generous and expensive.

The third [difference] is the size of the alliance. Our concept of the health alliance, or HPC (Health Purchasing Cooperative), was that government would organize a consumer choice market for the part of the market that is not now able to buy insurance efficiently and effectively, and that's the small group market, firms of 100 and under. That's probably half the population. The Clinton administration has said it's not

“

... Most providers are going to find far less paperwork and far less day-to-day oversight of clinical decision-making in this new system.

”

going to change the basic tax rule. It's going to have health alliances that include employers of up to 5,000, and it will have a global budget on premiums that fit within the Washington-set limit, which essentially limits the range of choices that consumers can make.

INDIANA MEDICINE: How will managed competition affect the way physicians practice?

Etheredge: Well, the actual practice of medicine is still up to the physician. [However,] they will increasingly have to contract with organized systems of care. Because the organized system is going to have to live within a premium, the terms of those contracts probably will include a negotiated payment rate and some agreement reached between the organization and the provider about quality and appropriate practice patterns. I think there's probably going to be very little change for most physicians. The way in which this is supposed to work, probably will work, is when an organized system tries to select who's going to be part of their network, they will look at the pattern of care of that individual physician and only contract with those who fit their philosophy or who they consider to be providers of good quality care. Really, [it's] the way in which you hire any employee or deal with any professional. You look carefully at their credentials and their standards, but then you stay out of their hair once you contract with them and review their performance periodically.

Secondly, most providers are going to find far less paperwork and far less day-to-day oversight of clinical decision-making in this new system. Far less paperwork because there will be standard policies. You don't have to worry about different policy coverage and different terms. Everyone is going to be covered, so you don't have to worry about bad debts any more. For physicians in rural areas, that's a big change. You don't have to worry about whether they can afford the therapy you're suggesting. [There

will be a] standard billing form, rather than hundreds of different forms. [There will be] electronic transmission and payment. Most physicians are going to get a tremendous reduction of paperwork.

They're also going to probably deal with many fewer payers than they do now. Most states now have hundreds of insurance companies. Under this reform, Indiana may be down to, I don't know, six or 10 major ones. But you're going to be dealing with the better companies who know what they're doing. So there's probably less hassle factor there.

And finally, as these groups put together these kinds of organizations, I think they'll know how to do networks. Smaller companies that are still in the insurance mode, you know, looking at bill by bill, claim by claim review and challenging those – that's the kind of thing that drives up the paperwork and drives people crazy.

The research so far shows that it takes about two to three years for these new organizations and relationships to begin working. Usually the first year physicians have a lot of problems because most of them have been lone

rangers. They're used to doing a lot of things and making a lot of decisions themselves. By the third year, either the organizations fold or they work really well. Physicians don't tolerate systems that don't work the way they think the system ought to work. So either the system gets shaped up or the doctors and hospitals go elsewhere. There may be a transition period, but I think the research so far indicates that after a little shakedown period physicians get quite happy with these kinds of systems.

If [these systems] work, they really have lots of advantages. They deliver patients to the doctor, for example. That's one of the real advantages to the physician of being part of a network. The network goes out and enrolls large employer groups. There are real efficiencies in purchasing equipment and supplies, real efficiencies in billing. Probably real efficiencies in getting malpractice insurance coverage. If you're part of an organized group which has 50,000 members, you've got some real clout. There's a lot less hassle factor if the organization's run well, a lot more time to spend on practicing medicine.

INDIANA MEDICINE: How will managed competition affect a rural family practitioner differently than a cardiologist in a big city?

Etheredge: I think the guy in the rural areas is just going to be swamped with patients because suddenly a lot of people who were uninsured or didn't have purchasing power are going to be able to go to a physician. So I think the difference may be greater demand in rural areas.

They're going to have much more business.

At the same time, some of the specialists in urban areas may find they have less business because they're in an oversupplied specialty. Specialists, if they are not part of a system, may find themselves down the food chain and being contracted with at reduced incomes. So if a physician were in an over-supplied specialty in a major urban area with a lot of effective purchasers, that physician should probably worry a bit about his or her economic future. For example, dermatology may be at risk in some areas because of the number of primary care physicians that think they can handle dermatology problems. The organization will contract selectively and quite competitively for their referrals.

INDIANA MEDICINE: How can managed competition work in sparsely populated rural areas where there often is a shortage of physicians?

Etheredge: In some parts it'll work extremely well. First, it has a couple key advantages. Giving everyone coverage [means] they can afford care and actually make choices. That'll help rural areas because they're undersupplied.

Secondly, the insurance market will work much better. Now there's up to 35% or 40% in brokeraged commissions on sales to individuals and small groups in rural areas. This'll be a much more efficient, less expensive insurance market with greater choice.

In terms of how it works, I think that will evolve by different rural areas. There are a number



of different areas classified as rural that actually are within driving distance of major medical centers, and those areas may see a lot of competition. There's one thing we do know about the medical system, and that is if the money's there, people will compete to provide the service. Now, we're not quite sure how well the cost-restraining parts of competition work in health care, which is what most of managed competition is about. But I'm fairly confident that if we put the demand there, we will probably see a lot more people interested in providing the services. Some of that will come from tertiary medical centers and referral hospitals. They may put clinics out in rural areas or underserved areas they haven't thought of before because they want to keep their beds filled. The Mayo Clinic's reaching out 150 miles, for example, and it's contracting. I would guess in rural areas there'll be fewer systems that people will have to deal with. In a major metropolitan area, physicians might wind up contracting with several systems.

INDIANA MEDICINE: Do you anticipate that individual physicians as we know them today will still be part of the game?

Etheredge: Maybe in rural areas. One thing that will happen with the market is if the demand goes up and supply is limited, incomes of rural physicians will go up. There are also some things in the Clinton plan that have loan forgiveness and health service scholarships and so on to help rural areas. I think rural areas will do quite well.

INDIANA MEDICINE: Some critics have said that managed competition will actually reduce access to health services and result in poorer quality care for low-income people. How do you respond to that?

Etheredge: Well, I think that's wrong. First, people are going to have guaranteed coverage, so they're going to have financial access regardless of who they work for or what their income is. Not only the 37 million uninsured but people who are locked into jobs because they have a preexisting condition. The worst thing right now is to be without insurance or on Medicaid. Those are the kinds of situations where people have poor access and low quality, and those are the problems that we should overcome.

The structure of managed competition is to give people choice, the financial means to choose among competing plans and to make an informed choice based on objective report cards of quality, cost and service. And if they don't like the quality that they get, if they don't like the service they get, they will be able to choose another plan. There are many more protections in this system than there are, for example, in a government-run system. A Medicaid enrollee today doesn't have a choice. If you don't like Medicaid, or if you don't like Medicare, the way they're controlling costs or the decisions they're making on what they cover, that's too bad. You're stuck with Medicare.

Maybe what you're getting at here is if we move into capitated systems like HMOs, that there's

an incentive in those systems to reduce health care services and not provide as much access. That's a concern. Badly run managed care organizations – there have been more than a few, unfortunately – have frequently started out by trying to compromise on quality or put up barriers to access. You call up and ask for a Pap smear, and you're told it's a three- to six-month wait, that kind of thing. That's the kind of thing we're trying to get rid of with this reform. And the way you get rid of it, I think, is through basic standards, being an accountable health plan, having health alliances, or HPCs, that qualify plans and have grievance monitoring, that have report cards that monitor how they're doing on these measures, and ultimately give consumers an informed choice about who's doing well in the market and who isn't.

With some of these rules, providers can't come in and cherry pick. They're going to have to compete with not just today's fee-for-service plans but six or 10 of the best plans in an area. So there's a high standard that new entrants are going to have to meet if they want the market. That's



the advantage of competition if this is structured right. You've got to meet the access and quality of your competition because consumers will always be able to choose another plan.

INDIANA MEDICINE: **How will managed competition affect the demand for primary care physicians versus specialists?**

Etheredge: Demand for primary care physicians will go up. Demand for a number of specialists will probably go down. Many advocates of managed care favor the primary care gatekeeper model where one doesn't get to a specialist unless one goes to a primary care physician. That's not part of the Clinton plan. It's not part of the managed competition philosophy, and I don't think it's necessarily the right model or the best model.

There is research that indicates that patients with chronic conditions like diabetes or heart disease do best when they have a specialist in that condition who is their primary care physician. I think everyone ought to have a primary care physician, but that doesn't mean it has to be a primary care specialist. They could still go to a cardiologist as their major source of care, and he could manage referrals. I don't think you have to be a board-certified family practitioner to be at the center of this system. But I think this is exactly the kind of thing that ought not to be decided in Washington. It really ought to depend on patients and physicians deciding who the patient wants to see and how the care is organized.

INDIANA MEDICINE: **What impact will managed competition have on medical education?**

Etheredge: Managed competition will probably shift medical education very sharply away from the ratios of 75% specialist and 25% generalist back toward a greater emphasis on primary care for three reasons. One, that's where the demand is going to be. Two, the government is probably going to redirect \$6 billion or \$8 billion of subsidy so that financial incentives will reallocate the residency

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Managed competition fundamentally shifts the incentives in health care to favor primary care and prevention.
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slots. Third, I think the medical schools are going to be in a very competitive environment in which they need to begin to emphasize primary care for their own financial futures.

The key point is that with aggressive competition in overpriced specialty care, where most of the oversupply is, it's the medical schools that are most at risk of seeing their revenues fall quite sharply because many of them have built their financial structures around highly paid insurance reimbursement for procedures that are likely to see price reductions in a competitive mar-

ket.

The real question is how to get the medical schools to respond. They've been subject to this criticism of producing an oversupply of specialists for years, but they haven't responded. I think there are few questions about the need to change medical education, whether we do managed competition or not. The tools for effecting that change really aren't part of managed competition. They mostly deal with the \$6 billion or \$8 billion of medical education subsidies that go out through the Medicare program, through the indirect medical education adjustments and disproportionate share hospital payments.

INDIANA MEDICINE: **How does managed competition emphasize primary care and prevention?**

Etheredge: Managed competition fundamentally shifts the incentives in health care to favor primary care and prevention. Once you've established a capitated payment to a system, that system has a very different set of incentives. Today, health care providers get paid more, the more illness they treat. In a capitated system, where the revenues are fixed, there's no more revenue from treating ill patients. All the incentives are to maintain wellness and to keep people well. So there's a real shift toward prevention and primary care.

Let me give you an example close to home. The head of the Maryland hospital commission dealing with health reform, the head administrator of Holy Cross Hospital, a good Catholic hospital

that's aggressively into neonatal care, into obstetrics and gynecology – they maybe do 20% of the deliveries in the state – that hospital administrator said what he likes most about managed competition is that it gives us the incentives to do what we should be doing all along, which is not to run the best neonatal intensive care unit in the area, but to get

out in the community with visiting nurses and others to make sure that people get the prenatal care that's going to prevent a high-risk pregnancy and [reduce] the demand for neonatal intensive care. He said if he can be part of a system that enrolls the people in his community, then we've got all the incentives in the right place to deal with these problems of im-

proving health care and actually preventing problem pregnancies. I think that's a very real example from an institution that is going to dramatically change the way it approaches serving a community if it gets a new incentive system. ▮

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.



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PHOs and POs: Should you take the plunge?

Bob Carlson
Indianapolis

How do you prepare for the emerging health care system?

Two options attracting considerable physician attention here in the Midwest and around the country are physician organizations, or POs, and physician-hospital organizations, or PHOs.

Some physicians are organizing themselves into POs. Others are joining forces with hospitals to form PHOs.

Is a PO right for you?

Or a PHO?

Maybe a PO and then a PHO?

The correct answer to all of the above is a resounding "That depends."

It depends on whether you are a primary care physician or a specialist; on your level of horizontal practice integration with other physicians; on your relationships with the hospitals with which you are affiliated; and on the market in which you practice.

Don't wait for Washington

How you practice medicine in the future also depends on federal health care reform legislation, but not as much as you might think. By the time Congress passes it and the president signs it, what comes out of Washington, D.C., is likely to have a lot in common with the innovative health care delivery systems that are now making history – and money – on

the West Coast, in the Twin Cities and in Albuquerque.

The reality is that the health care industry is in the midst of a historic change, a paradigm shift that's bigger than all of us. Think of it as a huge wave. If you decide to ride this wave of change, you'll be swept into uncharted waters. If you let the wave go by, you may find yourself treading water in the middle of the ocean.

For example, something like 80% of all PHOs exist on paper

The reality is that the health care industry is in the midst of a historic change, a paradigm shift that's bigger than all of us.

only, according to Nathan Kaufman, president of the Kaufman Group in San Diego, Calif. They are not viable, functioning business entities.

On the other hand, physicians on the West Coast who took a "wait and see" approach when POs and PHOs became popular there about 10 years ago are now experiencing "severe financial distress," according to Kaufman. His firm specializes in helping fee-for-service doctors succeed in a managed care environment.

What can we learn from successful, profitable POs and PHOs? What did they do that the others didn't? And why would doctors want to get into joint ventures with hospitals anyway?

What's a PO?

POs and PHOs are business entities created to take advantage of contracting opportunities by offering health care "products" that meet the needs of payers in the marketplace. Today, that means providing managed care services.

A PO, or physician organization, is a horizontally integrated organization of physicians. The spectrum of horizontal integration in a PO can range from a solo practice (no integration) on one

end through shared office arrangements, an independent practice association (IPA), a group practice without walls, a single specialty group, to a multispecialty group on the other

end.

In an IPA, for example, physicians build their patient base by participating in managed care contracts, but continue to practice in their own offices. In a more integrated PO, such as a multispecialty group, physicians share expenses, profits and office space. The group markets itself under a single name.

A PO can function as the physician component in the formation of a PHO. However, many PHOs are formed without first organizing a PO. Some well-known multispecialty group POs are the Permanente Group in California and the Lovelace Group in New Mexico.

What's a PHO?

A PHO, or physician-hospital

organization, is a vertically integrated entity formed jointly by a physician group and a hospital. When the physician group and the hospital have common goals, values and a shared vision for health care in their community, working cooperatively as a PHO can serve the best interests of the physician group, the hospital and the patients in the community.

PHOs are in the middle of the spectrum for integrated health care delivery systems, with "affiliation arrangements" or "management services organizations" on one end and foundations on the other. In a more integrated organizational structure, such as a foundation, there is more unity of purpose and a greater potential for managed care contracting. The trade-off is less autonomy for individual physicians.

PHOs provide a relatively flexible, balanced approach to health care delivery at the local level that can be appealing to both physicians and hospitals. Some of the more well-known integrated systems are the Henry Ford Health System in Detroit, the Marshfield Clinic in Wisconsin, the Ochsner Foundation in Louisiana and the Geisinger Foundation in Pennsylvania.

Each PHO is a custom-tailored entity, but some characteristics are common to all PHOs. The physician group and the hospital are equally represented on the PHO board of directors. The physicians bring their clinical expertise to the venture, while the hospital provides administration, marketing and capital. Together, the physicians and the hospital have a much better chance of developing and marketing successful managed care "products" than

Workshop to discuss POs, PHOs, managed care

"Decisions for Physician Success in the '90s and Beyond," a workshop hosted by the Indiana State Medical Association, will help physicians take charge of their future as health system reform evolves.

The daylong workshop will be held Wednesday, Jan. 26, from 8:30 a.m. to 4:30 p.m. at the University Place Conference Center on the Indiana University-Purdue University at Indianapolis campus. Presented in cooperation with the American Medical Association, the program will be divided in two segments, with the morning agenda devoted to physician organizations (POs) and physician hospital organizations (PHOs). The afternoon agenda on managed care will feature speakers and information developed by the AMA.

Topics will include the development and operation of successful POs and PHOs, options in managed care models and payment options and how to control clinical decision-making in managed care.

Speakers will include Thomas Gorey, J.D., president of Policy Planning Associates, a health care consulting firm in Lakewood, Ill.; Nathan Kaufman, president of the Kaufman Group in San Diego, Calif.; R. Terry Heath, J.D., an attorney with Hall Render Killian Heath & Lyman in Indianapolis; Alan Snell, M.D., South Bend, president and medical director of Michiana Healthnet; Evelyn Eskin, owner of HealthPower Associates, a Philadelphia-based practice management consulting firm; Judee Gallagher, J.D., a Chicago attorney concentrating in health care law; and Mark A. Hochstetler, M.D., vice president of managed health care at Parkview Memorial Hospital in Fort Wayne.

The registration fee is \$200 for ISMA members and \$300 for non-members and consultants.



Thomas Gorey



Nathan Kaufman

The AMA has designated the managed care segment of this workshop for four credit hours of Category 1 of the Physicians Recognition Award of the AMA.

For registration information, call Meg Patton at the ISMA, (317) 261-2060 or 1-800-257-4762. □

they would separately.

A marriage of convenience? Maybe. But with the economic incentives of both partners in alignment, a PHO can develop into a mutually satisfying and profitable relationship.

A prescription for success

The reason relatively few POs and PHOs make money is not because of any inherent flaws in the concept, says Kaufman. They are, however, very difficult to set up correctly. Managing care and assuming risk requires a completely different computer system, a claims processing system and a sophisticated utilization management system – in short, a management infrastructure that most hospitals and medical practices don't have.

But infrastructure is only one ingredient in the prescription for PO and PHO success, according to Kaufman.

"What happens is that either the hospital administration or medical staff go to a seminar and they come back and say we've got to get ready for health care reform and managed care, so we have to create a PHO. They typically will then hire an attorney and put the organization together and then nobody wants to buy the product. It's like setting up a factory before you decide what kind of product you want to make."

Thomas Gorey, president of Policy Planning Associates in Lakewood, Ill., agrees. "Establishing a PHO just to establish a PHO will almost surely doom the venture to failure."

Policy Planning Associates provides health care consulting services to physicians, hospitals, professional and trade associa-

tions. In the April 1993 issue of *Michigan Medicine*, Gorey identifies the following as key factors in PHO success.

- **Identification of need.** The physician group, the hospital group and the community identify common needs and interests.
- **Shared vision and commitment.** The physician group and the hospital articulate a shared vision of community health care that can best be achieved through physician-hospital cooperation.

• **Shared financial stake.** The physician group and the hospital each make more than a token financial commitment to the PHO.

• **Clear identification of goals, objectives and strategies.** A well-articulated strategic plan sets clear goals, objectives and strategies for the PHO, with measurable criteria for ongoing evaluation.

• **Utilization of an appropriate organizational model.** The PHO is designed to meet the unique needs of the physician group, the hospital and the community.

• **Clarification of roles / responsibilities.** The PHO is structured to affirm the physician role in clinical decision-making and the hospital role in business administration and marketing.

• **Governance.** The physician group and the hospital group have an equal voice in decision-making.

• **Avoidance of legal pitfalls.** PHOs are not without financial and legal risk. The physician group and the hospital group should retain separate legal and business counsel.

It's a new ball game

In light of all this information,

why are so many new POs and PHOs delivered stillborn?

For the same reason that IBM didn't see the PC revolution coming and General Motors was late in developing fuel-efficient, quality cars, says Kaufman. "We're seeing a structural change of similar magnitude in the health care industry, and it's hard for the current market leaders to shed traditional paradigms and respond appropriately. POs and PHOs are not extensions of the current delivery system. They're new businesses and need to be planned accordingly."

In other words, the paradigm has shifted. It's a new ball game with new rules. New Rule #1 is find out what the customers want to buy. Fee-for-service used to be the only game in town. In the new managed care environment, payers shop around for the best deal. "You either provide what the customers want or they'll go someplace else to buy," says Kaufman.

"The first question when setting up a PO or PHO," counsels Kaufman, "is what are we trying to accomplish, who are our customers, what do they want to buy and how do we structure an organization not to be attractive to the medical staff or the hospital administration, but to be attractive to the payers."

Gorey's prognosis for POs and PHOs in a managed care environment is cautiously optimistic. "Business is fed up with the cost of health insurance. I think the corporate community will be very supportive of POs and PHOs, to the extent that they can demonstrate the ability to deliver high quality, cost-effective care. Employers are clearly mov-

ing toward managed care, and it's going to affect virtually all physicians."

The new rules

How will the shift to managed care affect you?

In a primary care gatekeeper delivery system, for example, primary care physicians may be responsible for 70% of the patient visits and are likely to feel entitled to a preferential share of the ownership and the profits. Most tertiary hospitals now have a 30/70 ratio of primary care physicians versus specialists. In most managed care capitated delivery systems, that ratio is 50/50 and is expected to continue shifting toward a 70/30 ratio over the next 10 years.

Where does that leave the specialists? One answer may be to join PPOs. While most PPOs have fairly unsophisticated utilization management now, Kaufman thinks there will be substantial market opportunities for PPOs in the future.

Capitated managed care delivery systems such as HMOs depend on sophisticated utilization management systems to maintain their profitability. What happens to physicians who fall outside the norm, the so-called "outliers"? One strategy recommended by Kaufman is for both primary care physicians and specialists to contract with multiple POs and PHOs now.

But that advice isn't much help in identifying which organizations will still be around in a year. After all, there are plenty of POs and PHOs with no contracts and no revenue.

Kick the tires!

Gorey and Kaufman advise anyone considering a PO or PHO to visit some that work. That doesn't mean visit a consultant, but actually go to a PO or PHO, "kick the tires," talk to the doctors, talk to the patients, talk to the payers and look at the books. They also commend state medical associations who do this kind of field work and serve as information clearinghouses about POs and PHOs for their members.

As it happens, Gorey is coordinating just such a study on POs and PHOs around the country. He expects to issue a final report by February. The study is co-sponsored by the Indiana State Medical Association, the Illinois State Medical Society, the Michigan State Medical Society and the American Medical Association.

Possible side effects

Even if a physician succeeds in contracting with several well-designed, profitable POs and PHOs, he or she can count on giving up some degree of autonomy as a physician. Down the road, there is also the possibility that some physicians may no longer be allowed to participate in a PO or PHO because their utilization patterns don't meet the standards established by the organization.

"When forming POs and PHOs, physicians tend to look at their colleagues in an evaluative sense," Gorey notes. "They ask themselves, 'Is this someone who's going to help us bring in managed care business? Is this someone who's going to help us practice cost-effectively?' If not, they have to make a business decision as to whether they want

this physician to participate in their organization. I think most of them are going to be willing to make those hard decisions when it affects their pocketbook."

Some payers may simply prefer to contract with individual physicians rather than with a PO or PHO. Why? "Because they don't want to give an organization that much market power," says Kaufman. When it comes time to renegotiate the managed care contract in two or three years, taking their business elsewhere is not a credible option for payers because it means disrupting patient-doctor relationships.

What you should do now

If you practice in a rural community, you may be able to postpone joining a PO or PHO because there is less competition than in urban and suburban markets. If you are within five years or so of retirement, you will have considerably less incentive to get into POs and PHOs than someone with 10 or 20 years of practice remaining. All other physicians, says Kaufman, should have joined POs and PHOs yesterday. "I think it makes complete sense for physicians to join multiple POs and PHOs as soon as possible, provided these organizations have good, sound business plans."

Gorey predicates his timetable on the penetration of managed care in a market. "Ideally, physicians should be making these types of strategic decisions when their market is not a highly developed managed care market. In a market that's forty or fifty percent managed care, your choices are going to be limited because some of the less fully integrated models will not be capable of competing

against some of the more fully integrated models. In Indiana, this is probably a good time to be thinking about managed care and where you fit in."

Primary care physicians are in demand under managed care and they are in short supply, so it's no coincidence that hospitals have been buying primary care practices. That brings up an impor-

tant point to keep in mind when you choose people to advise you about forming a PO or PHO.

"It's important for physicians to make sure that whoever advises them in the process really has a neutral allegiance," cautions Kaufman. "For a PHO, the consultant usually will have to be paid by the hospital because this is not an inexpensive proposition.

The allegiance of these consultants and lawyers should be to create the most competitive organization possible. That means they can't show preference to the hospital, or to the physicians, for that matter." □

The author is a health care communications consultant in Indianapolis.

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How can you defer mutual fund taxable income and gains?

Joel M. Blau, CFP
AMA Investment Advisers Inc.

With interest rates at 20-year lows, investors have flocked to mutual funds with the hope of increased returns. Investors like mutual funds due to their professional management, diversification and verifiable audited past track records. Most mutual fund purchasers are long-term investors looking to supplement the retirement income received from their qualified retirement plans. Unfortunately, unlike the growth within a retirement plan, investors who own mutual funds outside of a retirement plan must pay taxes on the fund's income (other than municipal) and capital gains, as they are reported by the specific fund. While many mutual fund track records are impressive, it is important to look also at the after-tax returns of the funds, especially in light of the new higher tax brackets.

One strategy that can be used to minimize the effect of income taxation is to defer the income as well as the capital gains generated by the fund. This can be accomplished through the use of a variable annuity. This technique works best if withdrawals are not made until your retirement years. Gains on variable annuities are subject to a 10% IRS penalty if withdrawals are made before age 59 1/2, similar to the penalties associated with a qualified retirement plan. The difference is that only the gain is taxed and penalized under a premature distribution as opposed to the entire amount. Additionally, there are no IRS limits to the amount that can be invested in a variable annuity. You do not deduct the amount invested, but it does grow on a tax deferred basis. During retirement, you can then withdraw the funds as needed and pay income tax only on the amount of gain withdrawn, while the balance continues to grow on

a tax deferred basis.

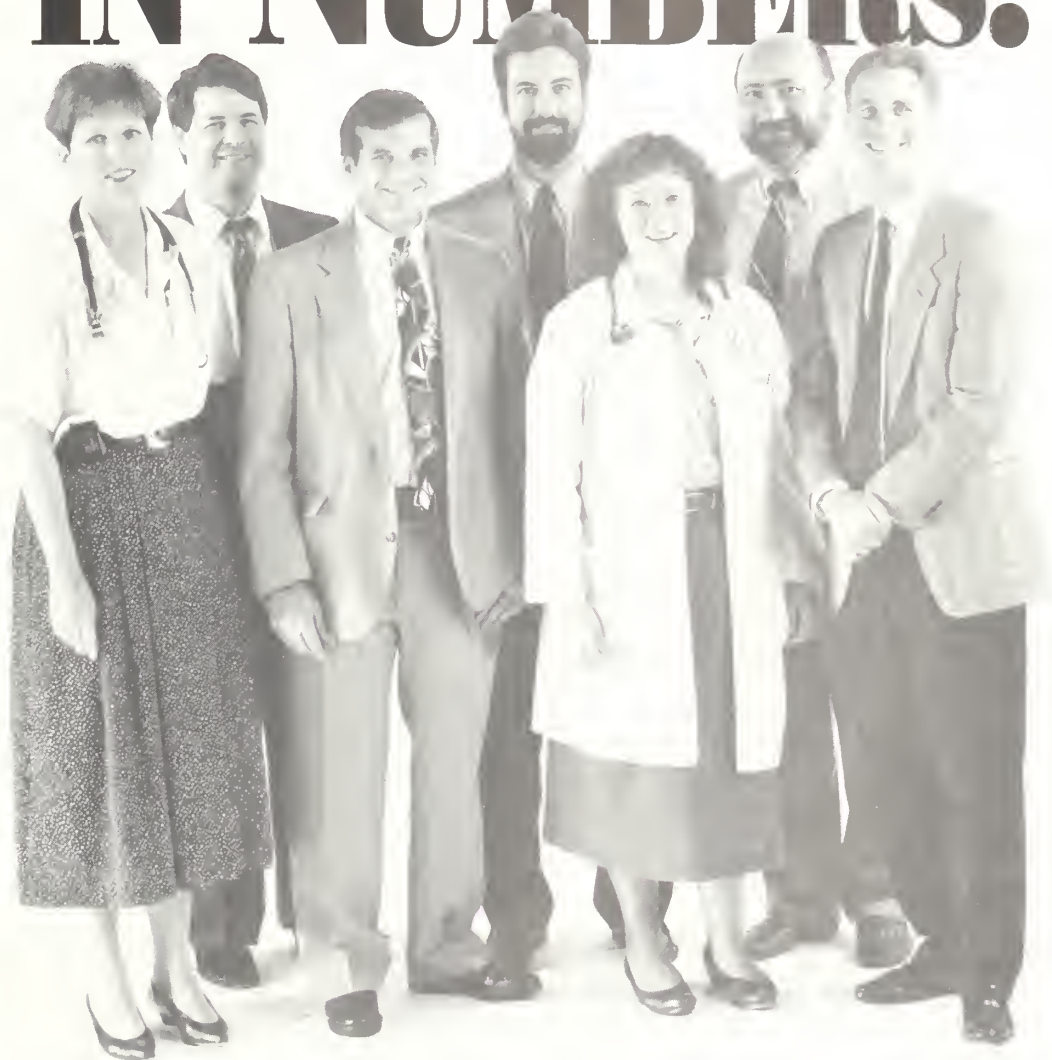
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The author welcomes readers' questions and can be reached at 1-800-262-3863.

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Tina Sims
Managing Editor

Thomas Moretto, M.D., was browsing through an antique store when he eyed a marble like one he remembered from his childhood. That boyhood memory sparked an interest that has continued to grow, until, he says, "50,000 marbles later, here we are."

Marble collecting fascinates Dr. Moretto, chairman of the family practice department at St. Vincent Hospital in Indianapolis and president of Group One Family Physicians. He is versed in the history of marbles, speaks the marble lingo, travels to marble shows and has given programs on marbles to schoolchildren.

He would never play the game of marbles, however. "I can't stand the thought of smashing them into each other," he says.

With his well-organized accumulation of varied and rare marbles, no one could blame him for wanting to keep them in good condition. He proudly explains the types of marbles he has amassed, including the following: Popeyes, clear marbles with two colors and so named because they came in a bag decorated with Popeye, the cartoon character; slags, machine-made imitations of old stone marbles; flames, marbles with a tongue of fire design; onion skins, marbles with all the color on the surface; Lutzes, which glisten like gold, but derive their sparkle from the use of cop-

per. Some names reflect the colors of the marbles: Christmas trees, red and green marbles; lemonades, whose yellow color results from the use of uranium oxide and which glow under a black light; limeades; and oxbloods, prized because of their rare color.

Sulphides are his most valued marbles, however. The clear glass marbles have figures such as animals or people in the center and rank among the rarest marbles. His favorite marble is a sulphide with a painted cat, a one-of-a-kind find located by his parents in an antique shop in Florida. Although the owner said the sulphide was not for sale, Dr. Moretto was able to negotiate a trade.

When possible, he prefers to trade marbles instead of buying and selling. Sometimes, however cash payments are the only option. When Dr. Moretto heard of a man who needed some money trying to sell 500 handmade marbles, he made a better offer than the antique dealers. Dr. Moretto was so pleased over the acquisition that on the way home, "we drove down the street, got out of the car and jumped up and down we were so excited."

He never knows where a sought-after marble will turn up, so scrupulous scanning is often required. If someone gives him a jar of marbles, Dr. Moretto and his wife, Louise, may spend the evening on the den floor scrutinizing each marble with a flashlight and a magnifying glass, looking for flaws. Certain imperfections can decrease the value of a marble, so unless a defective



Thomas Moretto, M.D., stores many of his marbles in this antique dental cabinet.

marble rounds out their collection of a certain category, he prefers to keep only the unblemished marbles.

Exceptions to this standard are the handmade marbles with pontil marks, the flat area that indicates where the marble was cut. Pontils were unavoidable until machines took over the job.

Although his collection includes both handmade and machine-made marbles, "we're still mainly handmade marble collectors," he says. When he does look for machine-made marbles, he seeks out those made from the 1890s to the 1940s.

Marbles date back to prehistoric times, he explains, noting that some were found in Egyptian tombs. The first glass marbles were made in the early 1800s. Before that, children played with clay or stone marbles.

Dr. Moretto's own children, he admits, have no interest in his hobby. "They think we're crazy," he says.

Apparently, the craziness has afflicted many people across the country. Dr. Moretto says there were not many marble collectors until about five years ago. "Now people are buying their childhood toys back," he says.

Marble hobbyists include people of all ages and in a variety of occupations, ranging from lawyers to truck drivers to farmers to teachers.

Collectors are becoming a technologically sophisticated group. Some collectors produce videotapes of their collections to use as marketing tools, although Dr. Moretto has not pursued the hobby to that extent.

He is, however, committed enough to collecting to marble hunt wherever and whenever



Dr. Moretto's collection includes marbles in a variety of designs and sizes.

possible. Before he visits his parents in Florida, for example, they place a classified advertisement for "marbles wanted" in the newspapers. When he arrives, the replies to the ad are waiting for him.

"Patients are good scouts for marbles," he says. As word of his hobby spreads, friends and professional colleagues help in the search. A pharmaceutical company representative presented him with a tie decorated with a marble motif.

He and his wife attend summer marble shows in Amana, Iowa, and Columbus, Ohio. "Marble people take over the Holiday Inn," setting up their displays in their rooms, ready to swap and sell, he says.

Dr. Moretto and his wife once asked a former classmate of Mrs. Moretto, Joe Rice, owner of the St. Clair Glass Factory in Elwood, to make 24 specially designed marbles for them to trade at a show.

"It doesn't take any space" is one reason Dr. Moretto enjoys the hobby. Storing marbles, unlike

antique cars or wicker furniture, is no problem, he says.

He has found attractive and creative ways to display and organize the marbles. An antique dental cabinet that Dr. Moretto refinished holds some of the collection; shelves behind glass doors are ideal for displaying the most attractive marbles, and slim drawers, lined with boards from which Dr. Moretto painstakingly cut marble-size circles, are suited for separating the marbles by category. Other marbles displayed in clear glass jars or jugs combine to form colorful pieces of art throughout the house.

"I think it's just the art" is another reason Dr. Moretto finds pleasure in the hobby. "I think about how these guys did this [made marbles] with pretty primitive equipment" and "am astounded" with the results, he says.

Dr. Moretto's appreciation for art is reflected in another hobby – painting. His paintings of barns and other outdoor scenery, all in soothing pastels, complement the decor of the Morettos' home. ▴

1993 ISMA convention highlights



William C. VanNess II, M.D., Summitville, addresses the opening session of the House of Delegates. Dr. VanNess took office as ISMA president during the convention.



George Branam, M.D., a Muncie pathologist, is the winner of the 1993 Physician Community Service Award. Dr. Branam helped raise more than \$40 million for Ball State University's "Wings Campaign" by soliciting help from the medical community. He is chairman of the Muncie/Delaware County Chamber of Commerce Task Force on Health Care and has served on the board of directors of the Muncie Symphony Orchestra and the Muncie Children's Museum. The award is given to a physician who has served his or her community by giving time in medical and non-medical capacities.



Pictured at President's Night are Dr. and Mrs. William C. VanNess II, left, and Dr. and Mrs. William H. Beeson. Dr. VanNess is serving as the 1994 ISMA president, and Dr. Beeson is immediate past president.



Members of a panel discussion on "The Road to Health System Reform" include, left to right, David Weinschrott, Ph.D., a research fellow at Hudson Institute in Indianapolis; Lynn Etheredge, a major architect of the managed competition idea and an independent consultant on health system reforms; and James Todd, M.D., executive vice president of the American Medical Association. Nearly 400 people attended the morning forum, which was followed by a reactor panel in the afternoon.



Participants on an afternoon reactor panel on health system reform include, left to right, Adrian C. VanderMast, state chairman of the health and long-term care committee of the American Association of Retired Persons; Jerry Payne, AFL-CIO; Christopher LaMothe, president of the Indiana State Chamber of Commerce; and John Knot, M.D., Lafayette, co-chairman of the ISMA health system reform task force. Panelists responded to remarks made by morning panelists and discussed their respective organizations' health system reform proposals.



Myra Selby, director of health care policy for Indiana, speaks during a morning panel discussion on health system reform.



Signing in at the registration desk are William Penland, M.D., left, and Omar Dukar, M.D., both Evansville ophthalmologists. Tom Martens of the ISMA staff is assisting them.



Members of Reference Committee 2 listen to comments on resolutions. They are, left to right, Stephen W. Perkins, M.D., an Indianapolis facial plastic and reconstructive surgeon; Don Smith, M.D., a South Bend dermatologist; William Pond, M.D., a Fort Wayne anesthesiologist; Jac Cooper, M.D., a Valparaiso surgeon; and Richard Pitman, M.D., a Columbus radiologist and committee chairman.



Sheilah Kast, an ABC News correspondent, addresses the audience during the annual IMPAC luncheon. Focusing her remarks on health system reform, Kast said she expects an employer mandate to be in the final reform package. She also told the crowd of physicians and spouses that in the end "the voice that is heard is loud, sure and comes from many throats."



Anne-Francis Nicol, M.D., right, a Logansport psychiatrist, talks to Sherri Bertram of Anthem Health Systems in the exhibit hall.



Kenneth J. Ahler, M.D., right, a Rensselaer family physician, talks to exhibitor Jerry Jacobson of the ISMA Insurance Agency.



Dr. and Mrs. Walter J. Daly enjoy the President's Night events. Dr. Daly is dean of the Indiana University School of Medicine.



Rosanna Iler of the ISMA staff, right, accepts a gift from Sue Ellen Greenlee, ISMA Alliance president, during an ice cream social in her honor. The alliance recognized Iler for her 25 years with the ISMA and for her service as executive director of the alliance.



Dr. and Mrs. John Osborne of Muncie pose during President's Night.



George Rawls, M.D., right, a past ISMA president, visits with exhibitors G.T. Lukemeyer II and Bridget Lukemeyer of the Confidential Medical Network.



Among those attending President's Night were John D. MacDougall, M.D., left, an Indianapolis surgeon, and Dallas E. Coate, M.D., a Lebanon family physician.



Richard Spalding, M.D., a Sellersburg internist, expresses his opinions during the meeting of Reference Committee 3.

ARNETT CLINIC

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In seven outpatient facilities, over 100 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The majority of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 320,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates:

- Cardiology
- Dermatology
- Family Medicine
- General Internal Medicine
- OB/GYN
- Oncology
- Orthopaedic Hand Surgeon
- Pediatrics

Practice Setting

At this time, over 100 physicians work for Arnett Clinic. One of the most practi-

cal reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information

Please contact: Physician Recruitment Department
Arnett Clinic, 2600 Greenbush Street
Lafayette, IN 47904 (317) 448-8000
Toll Free Nationwide, 1-800-899-8448



Lafayette, Indiana

1993 ISMA convention coverage

Call to order, miscellaneous business

The Indiana State Medical Association House of Delegates convened its 144th Annual Convention at 9 a.m., EST, Friday, Oct. 15, 1993, at the Westin Hotel in Indianapolis. The final session of the House of Delegates convened at 9 a.m., EST, Sunday, Oct. 17, 1993.

Presiding at both sessions was William Cooper, M.D., speaker, Columbus, assisted by Peter Winters, M.D., vice speaker, Indianapolis. Larry Allen, M.D., Anderson, served as parliamentarian. Paul Riley, M.D., Indianapolis, presented the invocation.

Approval of minutes

The proceedings of the 143rd Annual Meeting of the House of Delegates, Indiana State Medical Association, conducted Oct. 16-18, 1992, at the Westin Hotel, Indianapolis, and published in the January/February 1993 issue of INDIANA MEDICINE, were approved.

Addresses/reports

The addresses of the president, president-elect and president of the ISMA Alliance (all referred to Reference Committee 1) were filed with commendation.

All reports (printed in the September/October 1993 issue of INDIANA MEDICINE) were filed, with the exception of the treasurer's report, which is referred for audit.

Election of officers

William C. VanNess II, M.D., Summitville, president-elect, succeeded to the office of the president. William E. Cooper, M.D.,

Columbus, was elected president-elect. Other elections included:

Treasurer – Timothy N. Brown, M.D., Crawfordsville
Assistant treasurer – Frank M. Sturdevant, M.D., Valparaiso
Speaker of the House – Peter L. Winters, M.D., Indianapolis
Vice speaker of the House – John R. Thomas, M.D., Fort Wayne

Chairman, Board of Trustees – Jerome E. Melchior, M.D., Vincennes

Clerk/chairman pro tem, Board of Trustees, and at-large member, Executive Committee – Alfred C. Cox, M.D., South Bend

At-large member, Executive Committee – Stephen D. Tharp, M.D., Frankfort

Election of delegates, alternate delegates to the AMA

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association (terms expire Dec. 31, 1995).

Delegates:

John D. MacDougall, M.D., Indianapolis
Michael O. Mellinger, M.D., LaGrange
Marvin E. Priddy, M.D., Fort Wayne

Alternates:

William H. Beeson, M.D., Indianapolis
Barney R. Maynard, M.D., Evansville
George H. Rawls, M.D., Indianapolis

Holdover AMA delegates and alternate delegates (terms expire

Dec. 31, 1994) are:

Delegates:

Shirley T. Khalouf, M.D., Marion
John A. Knote, M.D., Lafayette
George T. Lukemeyer, M.D., Indianapolis

Alternates:

Alfred C. Cox, M.D., South Bend
C. Dyke Egnatz, M.D., Schererville
Max N. Hoffman, M.D., Covington

Trustees/alternates, 1993-1994

The House of Delegates confirmed the newly elected/re-elected trustees and alternates for 1993-1994.

Trustees:

District 1 – Barney R. Maynard, M.D., Evansville
District 2 – Jerome E. Melchior, M.D., Vincennes
District 3 – Gordon L. Gutmann, M.D., Jeffersonville
District 4 – Arthur C. Jay, M.D., Lawrenceburg
District 5 – Fred E. Haggerty, M.D., Greencastle
District 6 – Ray A. Haas, M.D., Greenfield
District 7 – Ron Stegemoller, M.D., Danville
District 7 – John M. Records, M.D., Franklin
District 7 – Bernard J. Emkes, M.D., Indianapolis
District 8 – John V. Osborne, M.D., Muncie
District 9 – Stephen D. Tharp, M.D., Frankfort
District 10 – Thomas A. Brubaker, M.D., Munster
District 11 – Laurence K.

Musselman, M.D., Marion
 District 12 – Joseph R.
 Manthey, M.D., Bluffton
 District 13 – Alfred C. Cox,
 M.D., South Bend
 RMS – Ruchir Sehra, M.D.,
 Indianapolis
 MSS – Scott Hollingsworth,
 Indianapolis

Alternate trustees:

District 1 – Bruce W. Romick,
 M.D., Evansville
 District 2 – James P. Beck,
 M.D., Washington
 District 3 – John H. Seward,
 M.D., Bedford

District 4 – Lawrence R. Bailey
 Jr., M.D., Aurora
 District 5 – Roland M. Kohr,
 M.D., Terre Haute
 District 6 – Howard C.
 Deutsch, M.D., Richmond
 District 7 – Frank Johnson,
 M.D., Indianapolis
 District 7 – Paula A. Hall,
 M.D., Mooresville
 District 7 – Girdhar Ahuja,
 M.D., Indianapolis
 District 8 – Susan K. Pyle,
 M.D., Union City
 District 9 – Daniel R. Berner,
 M.D., Lafayette
 District 10 – John L. Swarner,

M.D., Valparaiso
 District 11 – Regino B.
 Urgena, M.D., Marion
 District 12 – Brenda S. Stiles,
 M.D., Fort Wayne
 District 13 – Richard J. Houck,
 M.D., Michigan City
 RMS – Glenn A. Loomis,
 M.D., Indianapolis
 MSS – Michael Hardacre,
 Miller Beach

Future meetings

1994	Oct. 21-23	Westin
1995	Oct. 20-22	Radisson
	(tentative)	┐

In memoriam

The ISMA pays tribute to its members who have died since the 1992 session.

Paul Alvarez, M.D., Valparaiso
 Ivan Bennett, M.D., Indianapolis
 Mark Bevers, M.D., Seymour
 Anthony Blazys, M.D., South Bend
 Harry Brandman, M.D., Galesburg
 James R. Brown, M.D., Valparaiso
 Milton Caldwell, M.D., Terre Haute
 F.R. Carter, M.D., South Bend
 Violet Crabbe-Forbes, M.D.,
 Remington
 John De Fries, M.D., New Paris
 August Dian, M.D., Tampa, Fla.
 Clarence Ehrlich, M.D., Indianapolis
 Donald Ferguson, M.D., Anderson
 Samuel Ferrara, M.D., Peru
 Francis Ferry, M.D., Indianapolis
 Bill Freeland, M.D., Indianapolis

James Fuelling, M.D., Indianapolis
 Marjorie Galliher, M.D., Muncie
 Sprague Gardiner, M.D., Indianapolis
 Austin Gardner, M.D., Indianapolis
 Everett Gaunt, M.D., Alexandria
 Charles Geckler, M.D., Muncie
 William Gitlin, M.D., Bluffton
 Benjamin Grant, M.D., Gary
 Robert Hart, M.D., Columbus
 Warren C. Hastings, M.D., Fort
 Wayne
 Joseph Haymond, M.D., Indianapolis
 Herman Hepner, M.D., Kendallville
 William Holland, M.D., Indianapolis
 David E. Jones, M.D., Carmel
 King Jones, M.D., Michigan City
 Richard Karberg, M.D., Lafayette
 William Kendrick, M.D., Mooresville
 Herbert Khalouf, M.D., Marion
 Henry Leibundguth, M.D., Evansville
 Paul Lindenberg, M.D., Indianapolis
 Hamlin Lindsay, M.D., Indianapolis

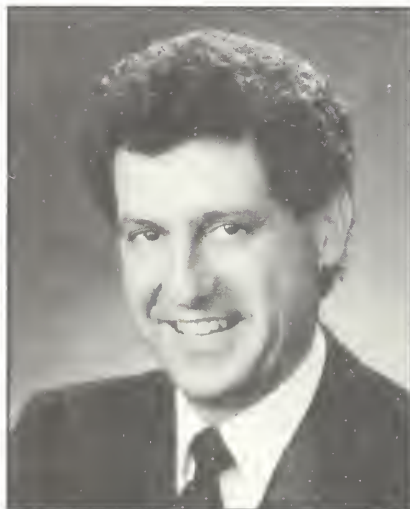
Adoracion Marquinez, M.D., East
 Chicago
 Merritt Mauzy, M.D., South Bend
 Louis Neudorff, M.D., Logansport
 David Phillips, M.D., Indianapolis
 Wayne Pippenger, M.D., Frankfort
 Frederick Poehler, M.D., Fort Wayne
 Frank Ramsey, M.D., Indianapolis
 Guy E. Ross, M.D., Naples, Fla.
 Paul Schmiedicke, M.D., Mulberry
 William Snively, M.D., Evansville
 Julius Steffen, M.D., Wabash
 John Stetson, M.D., Greencastle
 Maurice Turner, M.D., Indianapolis
 Virginia Wagner, M.D., Indianapolis
 Joseph West, M.D., Indianapolis
 Guido Wilhelm, M.D., New Castle
 Howard Williams Jr., M.D., Indian-
 apolis
 Ralph Wilson, M.D., Newburgh
 Ralph H. Young, M.D., Goshen ┐

William VanNess II, M.D., installed as president of the ISMA

William C. VanNess II, M.D., a Summitville family physician, took office as president of the Indiana State Medical Association Oct. 17 at the annual ISMA convention in Indianapolis.

A 1972 graduate of the Indiana University School of Medicine, Dr. VanNess is board certified by the American Board of Family Practice.

In addition to serving as speaker of the 1992 House of Delegates, Dr. VanNess has held the following positions with the ISMA: Eighth District trustee, chairman of the board and alternate delegate to the American



Dr. VanNess

Medical Association. He was president of the Madison County Medical Society in 1979.

Dr. VanNess has served as president of the medical staff of Community Hospital of Anderson, where he also has been chairman of the departments of internal medicine, pediatrics and family practice. He was team physician for Alexandria High School from 1979 to 1990 and had been a member of AIDS advisory committees at Alexandria and Madison-Grant high schools.

He received his bachelor of science degree from Butler University in 1968. □

William Cooper, M.D., chosen ISMA president-elect

William E. Cooper, M.D., a Columbus otolaryngologist, was chosen president-elect of the Indiana State Medical Association during its annual convention.

In addition to serving as speaker of the 1993 House of Delegates, Dr. Cooper has held the following positions with the ISMA: vice speaker of the 1992 House of Delegates, chairman of the board, and Fourth District trustee and alternate trustee.

A 1966 graduate of the Indi-

ana University School of Medicine, Dr. Cooper is certified by the American Board of Otolaryngology and is a fellow of the American College of Surgeons. He has served as president of the Indiana Academy of Otolaryngology/Head and Neck Surgery and is a member of the American Academy of Otolaryngology/Head and Neck Surgery. Dr. Cooper is on the staff at Columbus Regional Hospital, where he has served on a variety of committees. □



Dr. Cooper

Address of the president, William H. Beeson, M.D.

In the past 12 months, we have witnessed the ground swell of an emerging consensus in the need for health system reform. The Clinton administration has heard the reverberations of public opinion across our country and has proposed to Congress radical transformation in our health system. I think AMA Board of Trustees Chairman Lonnie Bristow put current events into proper perspective when he recently commented, "This is just the beginning of the most important domestic debate of our time."

While we are basically in harmony with the seven basic principles in the Clinton health reform proposal, actually they are embraced in the American Medical Association's Health Access America. We do have serious reservations and differences of opinion as to the focus for reform and the route that health reform should take. We are adamant that any reform should build on the strengths of our current system. We do not support the notion that the government is a paternalistic entity whose job it is to care for each of its citizens. We do not support the allocation of America's health care resources through a monopsony – an economic system with only one buyer. Instead, we believe that a pluralistic payment system is the right way, the American way, to go.

In recent years, health care has gone from a two-dimensional fraction of the doctor and patient to the three-dimensional isosceles triangle of medical care provider,

patient consumer and third-party financial broker. Now the federal government is imposing a fourth dimension with the imposition of expansive governmental control and oversight. The proposed health alliances and oversight will only add to the bureaucratization of the health care system, providing yet another layer of decision making that could undermine the important physician-patient relationship.

When a physician sits in an examining room with the patient, facing a difficult, often life-threatening, moment of decision, the physician needs to know without doubt that a decision can be made solely in the best interest of that patient's health and well-being and nothing else. As the president's proposal now stands, far too much could come between the physician and the patient at that moment of truth, making it difficult, if not impossible, to make the best decisions on behalf of patients. The combination of arbitrary global budgets, premium caps and the need to save dollars by health plans could necessitate many of the same obtrusive controls and second-guessing of physician decisions that exist in many of today's tightly controlled insurance plans.

This interference is, has been and continues to be inappropriate. It is inappropriate now when insurance companies second-guess a physician's clinical decisions, and when utilization review forces physicians to step out of the examining room to seek preauthorization for necessary care. It is inappropriate when the

threat of medical liability action forces physicians to order tests that would not be necessary in a less hostile environment. Under a new health care system, we must avoid interference that results from decisions about the availability and quality of health care made from a bureaucratic centralized place, distant from the patient's bedside and disconnected from the needs of the physician's individual patient.

Fueling physician concern over the president's proposal is the light brush that has been given to financing the proposed plan. The key revenue source offered is a continued federal cut-back in Medicare and Medicaid funding. Not only is this unacceptable to physicians and their patients who rely on these already underfunded programs, but it is doubtful that this can serve as a reliable revenue source to fund the expansion of health care access hoped for in the president's proposal. Heavy reliance on cuts in Medicare and Medicaid for financing is an unrealistic, short-term solution that could threaten medical services for our most vulnerable populations, the poor and the elderly.

Costs, budgets and economic uncertainty are an undeniable part of our lives today. If the United States productivity were keeping pace, if our federal deficit were under control, if the gross national product were growing faster than it presently is, then health care cost problems might have remained a cost crunch and not become the cost crisis we are caught in now. But it is a crisis –

a crisis that calls for reform. Today, the reality is not if the health care system is going to be changed, but rather how.

It is interesting that community leaders and experts understand the complexity of health care costs. They are aware of the interwoven problems such as duplication of technology and services, defensive medicine and the impact of demographic realities like crime, drug use, the aging population and the AIDS epidemic. But to the vast general public there is only one cause for high costs – greed. By this they mean unnecessary tests, overpaid doctors, wasteful hospitals, profiteering drug companies. To the public, it all adds up to a profit problem, not a cost problem.

Given this perception gap between leaders and the public-at-large, it is clear that we must work ardently to build solid public interest for a reasoned, thorough approach to reform. We really have only two choices. We can let an angry, frustrated, confused electorate mobilize the Congress. This Congress, desperately driven by the desire for re-election, might well produce hasty legislative action that will address only the costs of health care. Or as a second alternative, we as physicians can take the initiative to stimulate positive reform and thoughtful legislative action that will give us quality, excellence and value.

The choice is up to us. Those of us who are physicians count it as our personal privilege and responsibility to put our patients' well-being above our own. We count it as our privilege and responsibility to work for the public health in our communities and

our state. We as a group must summon all of our collective knowledge, ability and commitment to ensure that health system reform will always put patient care first.

Last year I appointed an ISMA Health System Reform Task Force, chaired by Drs. Mike Mellinger and John Knotte, with Drs. George Branam, Bernie Emkes, Barney Maynard, George Rawls, and Fred Ridge serving. In addition, all ISMA past presidents served as a special advisory council. This task force has produced a plan that I believe is more focused, addresses specific measures, starts to address access problems, starts to address the cost issues and does put patient care first.

The ISMA's health care proposal is not a simple, rigid or revolutionary plan but a compilation of workable, possible, evolutionary steps to reform what needs changing, while preserving what is good about health care in Indiana. It will be presented to this House of Delegates. You will be receiving it later today. Let me assure you that many of the elements in the ISMA plan can and should be implemented through state legislative action.

And that brings us to a critical issue. It is imperative that we become involved in the legislative process to protect the rights of our patients and the freedom to practice medicine as we know best and to affect legislative change positively. Never has a strong cohesive action-oriented medical society been so important to us all. But it cannot be strong or represent you effectively without your support, financially as well as intellectually.

Yesterday your Board of Trustees adopted the Dollar-a-Day program, where each physician is being asked to pledge one dollar a day to support our legislative efforts and issues. You probably have already discovered the pledge packets and buttons with your meeting materials. I would ask that you sign the pledge cards, remove the button and place it on your lapel. And as your president, let me be the first to join this effort. A dollar a day is a very small price to pay for good government and good legislation.

Before I leave today, I want to thank all of you for allowing me the opportunity to serve as your president. I owe a special debt of thanks to those of you who served on committees, commissions and special task forces, to the Board of Trustees, to the other officers, to the Alliance and to our outstanding staff, as well as all of you whose support and counsel have been invaluable to me. The past 12 months have been the most exciting and challenging of my life. I consider it the highest honor and privilege to have had the opportunity to serve as your president.

In closing, I am reminded that in the Chinese language the word "crisis" has a dual meaning – disaster and opportunity. I am fully confident that, under the leadership of Dr. Bill VanNess and your new officers, ISMA will effectively address the complex, multifaceted problems confronting us in this crisis, and that we truly will turn disaster into an opportunity to improve the health system and quality of care for our patients.

Thank you very much. J

Address of the president-elect, William C. VanNess II, M.D.

I would like to welcome everybody to our annual ISMA meeting. I am William C. VanNess II, M.D., and since I will be your president over this next year, I want to tell you a little bit about myself. I am a board-certified family practitioner, and I have been in practice since 1973. My office is in Summitville, where I was born and raised. It's a small rural town of about 1,000 people. I am married and am the proud father of four sons, ranging from 1 month today to 23 years of age.

There is a strong tradition of medicine in my family. My father was a general practitioner who returned to his hometown of Summitville in 1945 following five years of service in WWII. My involvement with medicine began when I was 3 years old and would toddle up to the office in the front of our house to tell my father good night. There were many days I would sit on my father's lap while he would see patients. At that point, I could see and sense the compassion and concern in his eyes for his patients, and in turn could recognize the trust in their eyes. As I grew older, I would frequently accompany my father on house calls throughout the countryside. This helped to confirm, in my mind, the significance of the patient-physician relationship.

My early contacts with medicine made it quite clear as to the tremendous stress and demands, both mentally and physically, placed on physicians and their families. Our living room was often used as the emergency

room. People would walk in bleeding, vomiting or collapsing from various illnesses. In spite of all this, I was determined to be a physician and have been fortunate enough to achieve that goal.

Each semester, I speak before a high school class in family living, and I'm asked if I like what I do. I always say, "No, I love what I do." And I am not alone in feeling that way about medicine and about patients. As I travel around the state, I have seen many physicians who are as dedicated and committed to their patients' well-being as I am. As you can see, I have been strongly connected with medicine over the past 44 years, and I now have a son who is a sophomore in med school. So the future of medicine and what happens to our patients and physicians is still very important to me.

My involvement in ISMA leadership began 11 years ago. Five years ago, I participated in a two-day retreat with other ISMA leaders where we developed an ISMA mission statement and planned our strategies for the future. We realized at that point that we did not have the resources to fully attack the many issues facing medicine. We needed to form a strategic plan that would focus us on a few specific priorities. In other words, we became a "lean, mean, fighting machine." This reminds me of my days at Butler as an undergraduate. In the college barber shop, there was a quote on the wall that read "It's not the size of the dog in the fight, it's the size of the fight in the dog!" And I'm here to tell

you that your ISMA leadership is ready to fight for you and your patients with all the strength and power of a pit bull.

The development of the strategic plan has allowed us, as an organization, to stay on the same track each year regardless of who comes in as the new president. This means that each year the agenda is to serve you and ISMA, not the individual president. This continuous agenda has helped us keep our focus, and therefore, ISMA has been a very effective voice for Indiana physicians.

If you look at the practice of medicine in Indiana, you will note that we do quite well relative to our peers in other states. Our medical liability law (the Indiana Compensation Act for Patients or INCAP) is unmatched in the country as a medical professional liability law. Trial lawyers have been attacking INCAP for years, but ISMA has proven successful in its protection of this very important act.

Many politicians around the country have proposed to tax physicians in order to balance their state budgets. These states include Minnesota, Kentucky and West Virginia. ISMA again has been a success by keeping this tax from becoming law in Indiana.

While the ISMA continues to work on your behalf, the many other services it provides you will continue. Consider the following membership benefits:

- Continued representation of your views on health and medical issues in meetings with our Indiana Congressional delegation

and the members of the Indiana General Assembly;

- Continued monthly meetings with the Medicare and Medicaid carriers on behalf of physicians and patients;
- Assistance with Medicare reimbursement problems;
- Practice management workshops;
- Advocacy for physicians through the courts on a host of ethical and legal questions affecting the practice of medicine;
- Periodic visits from your ISMA field representatives;
- Physicians Insurance Company of Indiana professional liability coverage; and
- ISMA-sponsored health and dental insurance.

I've heard James Todd, M.D., executive vice president for the AMA, state that trying to lead physicians is like trying to herd cats. Based on my 10 years' experience, this is most certainly true! But this is the time that we must all stay together to ensure that our patients continue to have rapid access to high-quality, affordable medical care. We need to protect the physician-patient relationship from intrusion from the government or by corporate medicine. Even though I am a family physician and a member of the Indiana Academy of Family Physicians and the American Academy of Family Physicians, I feel that the best way that I can help my patients keep their high quality of care is by working with and representing all M.D.s, not just my

specialty. Each of us works in our own branch of medicine, but if we are to be heard, we must speak with one voice. And I think this should be done through the ISMA and the AMA. We must be patient and not be coerced and frightened into participating in a health system that we do not support. We must not allow ourselves to be divided and conquered. It is crucial to remember that the system will not work unless we participate. They cannot do it without us!

I feel it is very important that we, in Indiana, nurture and expand upon the coalitions that have already been created. This includes continuing to meet with the presidents of the specialty societies and societies representing different ethnic groups of physicians. Also, I have been very pleased with the contact I have had with the ISMA Alliance, and feel they are one of our strongest allies. I have seen the dedication and commitment from our spouses, and I fully intend to capitalize on their spirit and enthusiasm.

The health care industry is the second leading employer in our country. It was the last industry still employing and growing until Clinton was elected. This means that there is a large group with common goals that have the potential for significant political power. They only need to come together and agree on a unified plan to reform our health system. Over the last year, we have had very productive meetings with the Indiana Hospital Association, and I guarantee that over this next year these meetings will continue. Hopefully, this will help produce a workable plan for the patients of

Indiana.

I recently came across an article containing some of the most astute observations I have read on health system reform.

In this month's issue of *Harper's* magazine, Dr. Willard Gaylin, a professor of psychiatry at Columbia University Medical School, addressed the process that produced the Clinton health proposal as "something akin to selection of a pope."

Here's how Dr. Gaylin described the process in the *Harper's* article: "Some five hundred health care experts met behind closed doors over a period of four months occasionally emitting smoke signals for the media laced with obscure acronyms and buzz words, such as HMOs, DRGs, global budgets and managed competition."

Dr. Gaylin says the Clinton administration has missed an opportunity to discuss the real issues, which we as a society must discuss to solve our health care cost crisis: issues such as "our attitudes toward life and death, the goals of medicine, the meaning of health, suffering versus survival, who shall live and who shall die and who shall decide."

Without discussing these issues, the Clinton plan is a contradiction, Gaylin says, because you cannot promise everyone everything without increasing the costs of our medical care – the costs that the president was elected to control.

The premise of Dr. Gaylin's article is that although we all agree that medical costs are too high, the Clinton plan is focusing on waste, fraud and abuse in the system – concepts easy to sell to the public – but the wrong targets.

I agree with the conclusions in Dr. Gaylin's article, that although waste exists in the system, health care costs are the result of the tremendous successes of medicine. We are successfully treating people for diseases that didn't exist 30 years ago. That, in part, has created a much greater demand in our system and even greater expectations from the public it serves.

"What we need is a way to confront the deeper and more challenging reasons for escalating health costs, which are our unbridled appetite for health care and our continuing expansion of the definition of what constitutes health," says Dr. Gaylin.

As I see it, we need to make some tough decisions as a society about how we allocate care. And the process should not be done behind closed doors by a board in Washington, but through open discussion by people in all walks of life. If we have to set limits on health care, we must do it as equitably as possible, and we all have a responsibility to contribute to that discussion.

Toward that goal, the ISMA Task Force on Health System Reform has worked diligently and has produced a very logical plan for health system reform in Indiana. I want to thank Dr. Mellinger and Dr. John Knotte, co-chairmen of the task force. Over the next three days, we all need to have a hard and intense debate on this proposal. The final results will give us a plan that we can support and take before our Indiana legislators this next session and whose principles we can stand behind on a national level.

America needs tort reform. It's estimated that \$30 to \$35 bil-

lion per year is spent on defensive medicine. Tort reform would have significant impact on lowering this outrageous figure. This could result in a significant savings that could be directly passed on to the consumer. Fortunately, Indiana has had a much more favorable climate when dealing with malpractice issues. Keeping INCAP intact will certainly remain a very high priority for ISMA.

ISMA and the AMA, along with our Alliance, are well aware of the problems with domestic violence in America. We feel that we can make a difference. As a result, I am forming a special ad hoc committee to address this important issue and make recommendations for ways to correct and improve this devastating problem.

Communication will be extremely important this next year. We must first be able to communicate among ourselves. To do this we will continue to distribute concise, accurate updates on our strategies by mail, fax, phone and district and county meetings. We welcome any suggestions that would help improve our communications to you. We must also communicate with our patients. Most of us do not have the time to spend telling each patient about our recommendations. It is our intent to provide each physician and his office with up-to-date summaries of our proposals so that this information could be put in with routine mailings to patients or set out in waiting rooms. Our telephone tree has been quite effective with key legislative issues. This also will continue and perhaps be expanded to improve physician-to-physician communi-

cation on all issues.

I would like to say that I am still quite proud of the quality of health care that we provide in America. We should not forget that more money is spent in America each year on entertainment than on health care. I know that we represent 14% of the gross national product and, for the benefits received by Americans, I do not feel that that is unreasonable.

I feel that if we must participate in a new health delivery system, there are several important issues that should be included.

1. Relief from anti-trust laws. Physicians must be able to form competing systems so they effectively negotiate with giant insurance and hospital plans. The law should specifically authorize and assist independently practicing physicians to form networks offering a full range of health care services.

2. All managed care plans must meet minimum standards for physicians' involvement in their medical policies concerning quality assurance, medical review, credentialing criteria. They must also be represented on the governing board and executive committees.

3. America needs a pluralistic and competitive system that gives all forms of reimbursement a fair chance to compete in the marketplace.

As a WWII history buff, I am reminded of a story about Admiral Bull Hulse. He was leading our fleet in one of the major prolonged sea battles of WWII. Near the end of the battle, after many men and ships were lost on both sides and the allies had clearly won the battle, a midshipman standing on the bridge near the

admiral said, "It's a blessing that we had so many extraordinary men to fight this battle." Hulsey replied, "We don't have extraordinary men, we have ordinary men responding to extraordinary times." This is how I see our battle, ordinary men and women and responding to extraordinary times. And we must respond,

and we must do it together.

I'd like to conclude by reciting a quote from Kipling's poem "The Law of the Jungle" that summarizes what I feel should be our approach to this coming year.

"Now this is the law of the jungle – as old and as true as the sky;

And the wolf that shall keep it

may prosper, but the wolf that shall break it must die;

As the creeper that girdles the tree trunk the law runneth forward and back –

For the strength of the pack is the wolf, and the strength of the wolf is the pack." □

Address of the ISMA Alliance president, Sue Ellen Greenlee

As ISMA Alliance president, I am delighted and honored to speak to you this morning and bring you an update on what your Alliance has been doing.

Just in case anyone needs to know, Alliance is the new name for the Auxiliary. We have over 2,000 members, both men and women, who are your spouses. We are part, hopefully an integral part, of the ISMA and work, like you, for the good of the medical community.

The Alliance is active, alive and aware.

Active – For the first time ever, I think we attended all 13 district annual meetings across the state and were on the business meeting agenda – to tell our story and make ourselves visible and to let you know that we're here. My personal feeling is that there are a lot of doctors and medical societies over Indiana who need to be informed on how valuable an asset they have in their local communities. We're the best kept secret in the medical profession!

I said we're active: Two of our programs this year are on eating disorders and its effect on

family life. Another Alliance ongoing program is our educational focus on the epidemic of domestic violence. We are proposing, along with the ISMA here at this House of Delegates, two resolutions – one for the marriage license and one for the birth certificate – that when they are given out that they contain a statement that says abuse is a crime and punishable by law. We have a goal that there should be a legislative meeting held in each county. We want to be a part, an active and positive part, of the new proposals for the health system in America.

Alive – With the hot topic of the year, health care system reform, we're educating ourselves to be informed and vocal on the issues being discussed.

We're out working for a good public image of what is right, realistic and works for medicine here at the grass roots level – talking to your patients, our friends and neighbors and to ourselves!

One program that Elkhart County just did is called the Mini-Internship Program where local business and political leaders follow physicians around for two

days to see and learn first-hand the health care delivery system in action. This is a terrific, positive public image "tool" that can help medicine. I encourage the medical societies to do such a program.

Aware – We're aware of the problems that are out there in the medical marriage and that we need to support each other. That's the uniqueness of our group. We, as physician spouses, live everyday with your stresses, which makes them our stresses. We see the effects on ourselves and our children. A study by the Menninger Clinic found that the number one source of conflict for both the doctor and the spouse is the lack of time for fun, family and self. Right now, jointly with ISMA, we are putting together a weekend seminar for medical couples to address such sensitive and timely concerns.

We're aware also and feel the need for medical families to do more activities together; we're continually being pulled apart – the wife, the husband, the children, all going in different directions. That's why Alliance is changing its convention to be at the same time as ISMA's each

October. We'll offer babysitting, child care and children's activities. We're doing all we can to encourage membership and attendance.

This is your Alliance – active, alive and aware.

This is my Alliance – an organization that is changing with the times. I feel deeply committed to it. I believe no one can care any stronger than myself – than your

own spouses – how vital physicians are to good health care, how caring physicians are about their patients and quality of life and how keeping a good, positive image for our home communities is the number one importance!

Alliance – active, alive and aware. We've had a good year. We're ready to work on today's challenges. We appreciate your

acknowledgment and your support.

Now, today, we have our county Alliance presidents here and very quickly, I would like to introduce them so you can see who the leaders are in your area. Please make contact with them, and thank them and their members for working for you.

Thank you. □

Scientific exhibitors

"Specificity of antibody associated with tolerance to peptidoglycan-induced hypophagia"

Exhibitors: David S. Darr, second-year medical student at Indiana University School of Medicine; co-exhibitors, Karla J. Biberstine, David E. Morgenstern, Raoul S. Rosenthal, Department of Microbiology and Immunology, Indiana University School of Medicine.

Intraperitoneal administration of soluble macromolecular peptidoglycan (PG; 250 µg/kg) suppresses appetite in rats. After four daily injections, rats become nonresponsive to PG-induced hypophagia. To determine if this acquired tolerance to PG, which persists for at least 30 days, correlates with the presence of anti-PG antibody (Ab), we developed an ELISA to detect Ab against Gram-negative PG. Sera from PG-tolerant rats had about eight-fold greater PG-specific Ab activity than sera from control rats, which received saline alone ($p < .05$). Homologous soluble PG was a

potent competitive inhibitor in the ELISA, but treatment of PG with muramidase reduced the inhibitory activity 10^3 -fold, indicating that most of the Ab was directed against polymeric units of the repeating disaccharide backbone. Purified disaccharide peptide monomers and peptide-crosslinked oligomers were also inhibitory (albeit less potent than macromolecular PG), suggesting that some Ab was specific for epitopes on individual disaccharide subunits or for the peptide-side chain. We conclude that tolerance to PG hypophagia is associated with Ab that might neutralize PG. Furthermore, the development of the ELISA should help us better define the role of PG and anti-PG Ab in other known host reactions (e.g., arthritis and slow-wave sleep), mediated by Gram-negative PG. □

"Ophthalmic RSDS"

Exhibitor: Lee Smith Jr., M.D., South Bend.

My first recognized patients

of reflex sympathetic dystrophy syndrome (RSDS) were referred by an anesthesiologist who was giving cervical and stellate ganglion blocks to these patients for pain relief. Some of these patients had or developed a conjunctivitis that I had diagnosed as chlamydia trachomatis, which seemed either refractory to treatment or recurred.

Doing an extensive ophthalmic examination on these patients revealed widespread involvement of changes in visual activity, in the presbyopia, inflammation of the conjunctiva and sclera, in 3-D, in convergence ability and in field losses, some rather extensive. The latter were of special interest because I recalled several cases examined for disability that were legally blind with only the findings of an unexplained field loss. In retrospect, I wondered how many may have been related to the RSDS. Details of ophthalmic findings of two cases are provided, giving treatment modalities and results of note. □

■ annual reports

Editor's note: These annual reports were not submitted in time to be included in the September/October 1993 issue of INDIANA MEDICINE.

FIRST DISTRICT

Bruce Romick, M.D., trustee;
Barney Maynard, M.D., alternate trustee

The physicians of the First District continue to remain committed to the work of the ISMA. The district has seen an increase in membership through the year. The annual district meeting was held at Sultan's Run Golf Club in Jasper. This move out of Evansville was a way of reaching out to the other areas of the district. The physicians of the First District also wish to recognize the spouses of the Vanderburgh-Southwestern Medical Alliance for their commitment to the work of organized medicine. They were extremely active during the legislative session, calling our local legislators, writing letters and staying informed on critical health issues.

The medical community of the First District continues to make an effort to understand and cope with the rapidly changing world of medicine. Six small group dinner meetings were held this summer in Evansville to discuss health care reform and to explore avenues through which the medical community can have a potential impact on the changes. These discussions reached 100 physicians and spouses. The First District will continue to play an active role in the legislative process - with the changes to come, we can hardly do otherwise.

FIFTH DISTRICT

Fred Haggerty, M.D., trustee

It has been a pleasure to serve as the Fifth District Trustee for the past three years.

The annual meeting was held at the Brazil Elks Club in May with good attendance. Our speaker, Lawrence Rink, M.D., from Bloomington spoke on the Olympic Games and medical problems there. I appreciate being able to report that at that meeting I was re-elected to serve another three years. Next year's annual meeting will be held in Terre Haute. We have held regular quarterly meetings, which have generally been successful and have generated considerable discussion.

A special thanks to those of you of the Fifth District who have made so many calls to legislators on behalf of ISMA in reference to proposed legislation. We all appreciate the help and guidance we frequently receive from the ISMA staff, and Janna Kosinski has been invaluable.

SIXTH DISTRICT

Ray Haas, M.D., trustee

Overall, the Sixth District had a good year. Membership apathy remains the greatest problem and is widespread throughout the district.

The quarterly meetings were very productive for planning future events and discussing current problems facing medicine. Our Sixth District annual meeting was held at the Westwood Country Club in New Castle. Following a golf outing, the members and guests viewed exhibits and talked

with pharmaceutical representatives of several companies. Fees charged to the pharmaceutical companies helped significantly in defraying the expenses of the meeting.

During the business meeting, William Toedebusch, M.D., assumed the office of district president. Dr. Toedebusch is to be commended for his willingness to not only serve as incoming president but for functioning as president during the preceding two terms due to unforeseen losses of preceding officers. Mark Lemmons, M.D., of Greenfield will serve as secretary next year.

After the business meeting and dinner, a discussion was held regarding organized medicine and government programs. This proved to be a very informative and stimulating highlight of the evening. It is unfortunate that more physicians were not in attendance.

On behalf of the Sixth District, I wish to express our extreme appreciation to Bob Sullivan and the ISMA staff for their assistance and support.

13TH DISTRICT

Alfred C. Cox, M.D., trustee

The 13th District held a special legislative meeting April 8 at Notre Dame to provide current information about various legislative issues affecting the Indiana General Assembly. William Beeson, M.D., ISMA president, and Alfred Cox, M.D., 13th District trustee, presented the information to 58 members in attendance.

The annual meeting was hosted by the Marshall County

Medical Society at Culver Cove. Michael Deery, M.D., 13th District president, presided over the activities. Several members enjoyed golf at the U.S. Golf Academy, Swan Lake. The meeting featured entertainment by harpist Beth

Pare and the Maxinkuckee Players.

I would like to thank Richard Houck, M.D., for his work as the 13th District alternate trustee and John Schurz, M.D., for his work as district treasurer.

The 1994 meeting will be moved to March and will be hosted by the Elkhart County Medical Society and 1994 District President Alan Bierlein, M.D. ▮

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For more information, call John Mayer at 1-800-442-ISMA

RESOLUTION 93-1 Prohibit Corporal Punishment in Indiana Schools

Introduced by: John W. Luce, LaPorte County
Referred to: Reference Committee 1
Action: Adopted

RESOLVED, That current ISMA policy on corporal punishment be reaffirmed; and be it further

RESOLVED, That the ISMA encourage schools and licensed day care facilities to develop and implement effective, innovative, appropriate and positive behavioral management programs.

RESOLUTION 93-2 Indemnification of Officers & Trustees

Introduced by: ISMA Executive Committee
Referred to: Reference Committee 2
Action: Adopted

Whereas, The ISMA desires to provide indemnification to officers and trustees in the event they are involved in litigation or incur other liability as a result of acting in their "official capacity" as defined by Indiana law; therefore be it

RESOLVED, That the following language be incorporated into the ISMA Constitution and Bylaws at the appropriate place as determined by the ISMA Commission on Constitution and Bylaws:

ARTICLE - INDEMNIFICATION OF OFFICERS AND TRUSTEES

Section _____: Definitions.

(a) The term "trustee" means an individual who is or was a trustee of the Association or an individual who, while a trustee of the Association, is or was serving at the Association's request as a trustee, officer, partner, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan or other enterprise, whether for profit or not. A trustee is considered to be serving an employee benefit plan at the Association's request if the trustee's duties to the Association also impose duties on, or otherwise involves services by, the trustee to the plan or to participants in or beneficiaries of the plan. "Trustee" includes, unless the context requires otherwise, the estate or personal representative of a trustee.

(b) The term "expenses" includes all direct and indirect costs (including without limitation counsel fees, retainers, court costs, transcripts, fees of experts, witness fees, travel expenses, duplicating costs, printing and binding costs, telephone charges, postage, delivery service fees and all other disbursements and out-of-pocket expenses) actually incurred in connection with the investigation, defense, settlement or appeal of a proceeding or establishing or enforcing a right to indemnification under this Article _____, applicable law or otherwise.

(c) The term "liability" means the obligation to pay a judgment, settlement, penalty, fine (including excise tax assessed with respect to an employee benefit plan), or reasonable expenses incurred with respect to a proceeding.

(d) The term "official capacity" means:

(i) When used with respect to a trustee, the office of a trustee in the Association; or

(ii) When used with respect to an individual other than a trustee, as contemplated in Section herein, the office in the Association held by the officer or the employment or agency relationship undertaken by the employee or agent on behalf of the Association.

"Official capacity" does not include service for any other foreign or domestic corporation or any partnership, joint venture, trust, employee benefit plan or other enterprise, whether for profit or not.

The term "party" includes an individual who was, is or is threatened to be made a named defendant or respondent in a proceeding.

The term "proceeding" means any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative and whether formal or informal.

Section _____: Conditional Indemnification. The Association shall indemnify an individual made a party to a proceeding because the individual is or was a trustee against liability incurred in the proceeding if:

a) The individual's conduct was in good faith;

■ resolutions

b) The individual reasonably believed:

- (i) In the case of conduct in the individual's official capacity with the Association, that the individual's conduct was in its best interest; and
- (ii) In all other cases, that the individual's conduct was at least not opposed to its best interest; and

c) In the case of any criminal proceeding, the individual either:

- (i) Had reasonable cause to believe the individual's conduct was lawful; or
- (ii) Had no reasonable cause to believe the individual's conduct was unlawful.

A trustee's conduct with respect to an employee benefit plan for a purpose the trustee reasonably believed to be in the interest of the participants in and beneficiaries of the plan is conduct that satisfies the requirement of subsection (b) above.

The termination of a proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent is not, of itself, determinative that the trustee did not meet the standard of conduct described in this Section _____.

Section _____: Mandatory Indemnification.

The Association shall indemnify a trustee who was wholly successful, on the merits or otherwise, in the defense of any proceeding to which the trustee was a party because the trustee is or was a trustee of the Association against reasonable expenses incurred by the trustee in connection with the proceeding.

Section _____: Court-Ordered Indemnification.

A trustee of the Association who is a party to a proceeding may apply for indemnification to the court conducting the proceeding or to another court of competent jurisdiction. On receipt of an application, the court, after giving any notice the court considers necessary, may order indemnification if it determines that:

(a) The trustee is entitled to mandatory indemnification under Section _____, in which case the court shall also order the Association to pay the trustee's reasonable expenses incurred to obtain court-ordered indemnification; or

(b) The trustee is fairly and reasonably entitled to indemnification in view of all of the relevant circumstances, whether or not the trustee met the standard of conduct set forth in Section _____.

Section _____: Advancement of Expenses Prior to Final Disposition. The Association shall pay for or reimburse the reasonable expenses incurred by a trustee who is a party to a proceeding in advance of final disposition of the proceeding if:

(a) The trustee furnishes the Association a written affirmation of the trustee's good faith belief that the trustee has met the standard of conduct described in Section _____.

(b) The trustee furnishes the Association a written undertaking, executed personally or on the trustee's behalf, to repay the advance if it is ultimately determined that the trustee did not meet the standard of conduct; and

(c) A determination is made that the facts then known to those making the determination would not preclude indemnification under this Article _____.

The undertaking required by subsection (b) must be an unlimited general obligation of the trustee but need not be secured and shall be accepted without reference to financial ability to make repayment.

Determinations and authorizations of payments under this Section shall be made in the manner specified in Section _____.

Section _____: Procedure. The Association may not indemnify a trustee under Section _____ unless authorized in a specific case after determination has been made that indemnification of the trustee is permissible under the circumstances because the trustee has met the standard of conduct set forth in Section _____.

The determination shall be made by any one of the following procedures:

(a) By the Board of Trustees by majority vote of a quorum consisting of trustees not at the time parties to the proceeding;

(b) If a quorum cannot be obtained under subsection (a), by majority vote of a committee duly designated by the Board of Trustees (in which designated trustees

who are parties may participate), consisting solely of two or more trustees not at the time parties to the proceeding;

(c) By special legal counsel:

(i) Selected by the Board of Trustees or its committee in the manner prescribed in subsection (a) or (b); or

(ii) If a quorum of the Board of Trustees cannot be obtained under subsection (a) and a committee cannot be designated under subsection (b), selected by majority vote of the full Board of Trustees (in which selection trustees who are parties may participate).

Authorization of indemnification and evaluation as to reasonableness of expenses shall be made in the same manner as the determination that indemnification is permissible, except that if the determination is made by special legal counsel, authorization of indemnification and evaluation as to reasonableness of expenses shall be made by those entitled under subsection (c) to select counsel.

Section _____: Indemnification of Association Employees Other Than Trustees. An officer of the Association, whether or not a trustee, is entitled to mandatory indemnification under Section _____ and is entitled to apply for court-ordered indemnification under Section _____, in each case to the same extent as a trustee. The Association shall indemnify in advance expenses to an officer, employee or agent of the Association, whether or not a trustee, to the same extent as to a trustee. The Association shall also indemnify in advance expenses to an officer, employee or agent, whether or not a trustee, to the extent, consistent with public policy, that may be provided by general or specific action of its Board of Trustees, the Association's Bylaws or contract.

Section _____: Liability Insurance. The Association may purchase and maintain insurance on behalf of an individual who is or was a trustee, officer, employee or agent of the Association, or who, while a trustee, officer, employee or agent of the Association, is or was serving at the request of the Association as a trustee, officer, partner, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan or other enterprise, against liability asserted against or incurred by

the individual in that capacity or arising from the individual status as a trustee, officer, employee or agent, whether or not the Association would have power to indemnify the individual against the same liability under Section _____ or _____.

Section _____: Miscellaneous. The indemnification and advance for expenses provided for in this Article _____ does not exclude any other rights to indemnification and advance for expenses that a person may have under a resolution of the Board of Trustees or any other authorization, whenever adopted, after notice, by majority vote of all the voting shares then issued and outstanding.

This Article _____ does not limit the Association's power to pay or reimburse expenses incurred by a trustee, officer, employee, or agent in connection with the person's appearance as a witness in a proceeding at a time when the person has not been named a defendant or respondent to the proceeding.

The provisions of this Article _____ shall be in addition to and not in limitation of any other right of indemnification and reimbursement or limitations of liability to which any trustee or officer may be entitled to as a matter of law.

RESOLUTION 93-3

Introduced by:

Referred to:

Action:

Death With Dignity

James Reidy, M.D., Charles Walters, M.D., and the St. Joseph County Medical Society

Reference Committee 3

Adopted

Whereas, Patients often express the right to die in peace without the need to prolong their life when they are terminally ill, or in a vegetative state that is unlikely to improve, and

Whereas, Certain medical procedures, which include but are not limited to: cardiopulmonary resuscitation, use of a respirator, nasogastric feeding tubes, gastrostomy feeding tubes or indefinite use of IV fluids, have the capability to prolong the dying process or the vegetative state, and

Whereas, The current state law allows patients to express their wishes through advance directives like the living will, which allows the terminally ill patient or the hopelessly vegetative patient the right to refuse cardiopulmonary resuscitation and the use of a respi-

■ resolutions

rator, but not the right to refuse nasogastric feeding tubes, gastrostomy feeding tubes, or indefinite use of IV fluids, therefore be it

RESOLVED, That the state legislature amend the statutes so the patient or his legal representative, and not the state, be given the option to choose or refuse procedures that may prolong the dying process or prolong the hopeless vegetative state; and be it further

RESOLVED, That nasogastric tube feedings, gastrostomy feeding tubes and IV fluids be added to cardiopulmonary resuscitation and respirator care as an option for patients to decide upon when making their advance directives.

RESOLUTION 93-4 Speaker & Vice Speaker of the House of Delegates

Introduced by: ISMA Executive Committee
Referred to: Reference Committee 2
Action: Adopted

Whereas, pursuant to Section 3.0201 of the ISMA Bylaws, the composition of the House of Delegates consists of the following voting and non-voting members:

Voting members

- 1) Delegates or designated alternates elected by the component societies
- 2) Trustees or designated alternates
- 3) Speaker
- 4) Vice Speaker
- 5) Past Presidents

Non-voting members

- 1) President
- 2) President-elect
- 3) Executive Director
- 4) Treasurer
- 5) Assistant Treasurer
- 6) Delegates and alternate delegates to the American Medical Association
- 7) Section delegates or designated alternate delegates, and

Whereas, Section 4.0306 and Section 4.0307 require the speaker and vice speaker of the House of Delegates to be elected annually from the delegate members of the House, and

Whereas, there is no compelling reason to require

the speaker or vice speaker to be a delegate member of the House of Delegates, as opposed to another classification of House member, if that is the desire of the House, now therefore be it

RESOLVED, That Section 4.0306 be amended to read as follows, "Speaker: The speaker shall be elected annually from the delegate members of the House ... ;" and be it further

RESOLVED, That Section 4.0307 be amended to read, "Vice Speaker: The vice speaker shall be elected annually from the delegate members of the House ..."

RESOLUTION 93-5 Restrictive Covenants/AMA Ethics/Indiana Law

Introduced by: Alvin Haley, M.D.
Referred to: Reference Committee 1
Action: First three resolves adopted; last resolve referred to Board of Trustees

Whereas, restrictive covenants between physicians became unethical in Indiana when the Indiana State Medical Association House of Delegates adopted substitute resolution 71-2; and

Whereas, health care reform and its anticipation potentiates the number of contracts entered into by physicians; and

Whereas, restrictive covenants by their nature tend to be anti-competitive; and

Whereas, enforcement of a restrictive covenant may intensify geographic maldistribution of physicians; and

Whereas, restrictive covenants may violate the civil rights of physicians and patients; and

Whereas, the Council on Ethical and Judicial Affairs of the AMA only discourages any agreement between physicians which restricts the right of the physician to practice medicine for a specified period of time or in a specific area upon termination of employment or partnership or corporate agreement although it states such restrictive agreements are not in the public interest; now therefore be it

RESOLVED, That the Indiana State Medical Association reaffirm its decision that restrictive covenants between physicians are unethical; and be it further

RESOLVED, That the ISMA declare that a restrictive covenant between a physician and any entity be declared unethical; and be it further

RESOLVED, That the ISMA Delegates to the

AMA be instructed to present this resolution to the AMA House of Delegates at its next meeting in order to cause the AMA Council on Ethical and Judicial Affairs to declare such restrictive covenants unethical in other states; and be it further

RESOLVED, That the ISMA lobby the Indiana General Assembly to make a restrictive covenant between a physician and any entity illegal in Indiana.

RESOLUTION 93-6 Integrated Health Education for Adolescents

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 1
Action: Referred to Board of Trustees for implementation

Whereas, the National Commission on Adolescent Health and other national and state committees on adolescent health recommend comprehensive, integrated health education programs that give special attention to developing problem solving and decision making skills; and

Whereas, these committees recommend that educators and health care providers work together to respond to the adolescent health care crisis by supporting appropriate, affordable comprehensive health education programs; and

Whereas, comprehensive health education has not been a funding priority for Indiana school systems because of the high cost of most programs; and

Whereas, Indiana schools do not presently utilize the health education proficiency guidelines developed by the Department of Education; therefore be it

RESOLVED, That the ISMA encourage the increased use of integrated, comprehensive health education curriculum from K through 12th grade in the Indiana school system, as a funding priority; and be it further

RESOLVED, That the ISMA develop a comprehensive, integrated, health education program similar to the inexpensive Vector Quest program used in Iowa public school systems, which emphasizes engaging students' interest in health-related issues and relies strongly on developing individual decision making, problem solving skills in adolescents. This would then be made available to the Department of Health and Department of Education as recommendations

from ISMA for health education curriculum.

RESOLUTION 93-7 Smoking Ban for Adolescents

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, studies show that 15% of all high school students smoke tobacco daily and that smokeless tobacco use by adolescents has increased to 9% who use it regularly; and

Whereas, the Indiana survey, done in 1992 on adolescent health behaviors, shows that 20% of all ninth graders and 33% of all 12th graders have smoked cigarettes or used smokeless tobacco in the past 30 days; and

Whereas, tobacco is the most important single preventable cause of death in the United States; and

Whereas, early use of tobacco and other addictive substances has proven to be associated with abuse of these substances in later adulthood; and

Whereas, childhood is the prime time to affect human development and behavior; be it therefore

RESOLVED, That the ISMA seek legislation to ban smoking and the use of all tobacco products in all public schools and on all school grounds in Indiana.

RESOLUTION 93-8 Bicycle Helmets

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, national studies show that "the leading cause of death in childhood is unintentional injuries, that are also the most preventable"; and

Whereas, 30% of motor vehicle fatalities are related to motorcycle, pedestrian and bicycle casualties, which has caused the National Commission on Adolescent Health Care to recommend that "increasing helmet use would provide substantial benefit"; and

Whereas, the Indiana Student Health Survey of 1992, demonstrates that "87% of all ninth grade and 63% of all 12th grade students never wear bicycle helmets"; therefore be it

■ resolutions

RESOLVED, That the ISMA seek legislation requiring the use of bicycle helmets for bicyclists for up to the age of 18 years old; and be it further

RESOLVED, That the county medical societies work with their component alliances and any other interested organizations to promote the use of bicycle helmets by all bicyclists.

RESOLUTION 93-9 School-Linked Health Care Programs

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, the National Commission on Adolescent Health Care recommends school-linked, adolescent health services that are coordinated with local health care providers as an effective way to meet the needs of underserved adolescents; and

Whereas, studies also show that adolescents who seek assistance for one health problem have a high frequency of other "hidden" health problems underlying the present complaint that make comprehensive, coordinated health services crucial; and

Whereas, the Code Blue Commission Report on Adolescent Health Care finds that school nurses, health education and physical education programs do not meet the current adolescent health care needs; therefore be it

RESOLVED, That the ISMA encourage school-linked health programs that require school nurses, guidance counselors or other appropriate school personnel to work together with parents to refer students who need health care to appropriate health care providers.

RESOLUTION 93-10 Community Coalitions Focused on Adolescent Health

Introduced by: Adolescent Preventive Health Care Task Force
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, national and state studies have shown that "poor health among America's adolescents has

reached crisis proportions, and large numbers of adolescents suffer from depression; jeopardize their future by abusing illegal drugs, alcohol and tobacco; engage in premature, unprotected sexual activity; frequently are the victims of violence; and lack proper nutrition and exercise"; and

Whereas, one-fourth of adolescents by age 15 are engaged in behaviors that are harmful to themselves, and 7 million adolescents between age 10 and 18 are at serious risk of being harmed by health threatening, even life threatening activities, and another 7 million children are at moderate risk; and

Whereas, the Code Blue Report and the National Commission on Adolescent Health Care recommend developing local coalition-building with school faculty, parents and health providers; therefore be it

RESOLVED, That physicians and the ISMA Alliance be encouraged to educate themselves and the community on adolescent health needs; and be it further

RESOLVED, That the ISMA encourage the ISMA Alliance to establish coalitions in its districts with school boards, school nurses, guidance counselors or other appropriate personnel for the purpose of facilitating communication of adolescent health needs and the utilization of the local medical community to help meet those needs.

RESOLUTION 93-11 In-School Screenings for Children at Risk for Certain Psychiatric Illnesses

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 3
Action: Referred to Board of Trustees

Whereas, there is a 5% prevalence rate for attention-deficit and hyperactivity disorders, data that suggest that 25% of all children are physically or sexually abused at some point in their childhood, data that show that depression affects up to 33% of all adolescents, and data that demonstrate that the suicide rate for adolescents age 10 to 14 has tripled and the suicide rate for teens age 15 to 19 has doubled, and

Whereas, all these disorders place children at risk of academic failure and significant morbidity if treatment is not given, but these disorders are very responsive to treatment; and

Whereas, a simple, inexpensive screening process could be developed to identify children who might benefit from further evaluation and treatment; now therefore it be

RESOLVED, That the ISMA, working with the Indiana Academy of Child and Adolescent Psychiatry, establish screening criteria for attention-deficit and hyperactivity disorder and for depression or post-traumatic stress disorder; and be it further

RESOLVED, That the ISMA seek legislation that will mandate the annual use of these screens in the Indiana school system, requiring schools to be responsible for documenting the results of these screens and for referring students with abnormal results for appropriate health care.

RESOLUTION 93-12 Physical Fitness Programs for Adolescents

Introduced by: Adolescent Preventive Health Care Task Force, William VanNess II, M.D., chairman
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, only 32% of children in grades 1 through 6 and only 44% of children in grades 7 through 9 participate in daily physical education programs, and only 47% of 12th grade students in Indiana engage in moderate physical exercise or sports activities three or more days a week; and

Whereas, moderate to vigorous physical activity on a regular basis promotes overall fitness and weight control; and

Whereas, noncompetitive physical fitness programs, like aerobic exercise, are an inexpensive but proven method for promoting physically healthy lifestyle choices throughout adulthood; and

Whereas, the present competitive school sports program, according to national adolescent health studies, does not meet the physical fitness needs of the majority of school age children; therefore be it

RESOLVED, That the ISMA and the ISMA Alliance encourage the development of noncompetitive, self-improvement physical fitness exercise programs throughout all school systems in Indiana from K through the 12th grade.

RESOLUTION 93-13 Hospital Staff Consultation in Suspected Terminal Cases

Introduced by: George H. Rawls, M.D., and the Indianapolis Medical Society
Referred to: Reference Committee 4
Action: Adopted

Whereas, the cost of medical care is increasing at an annual rate over 10%; and

Whereas, a large part of money spent on medical care during one's lifetime occurs in the last six months of one's life; and

Whereas, it is difficult for the individual physician to recommend the cessation of heroic measures in obviously terminal cases; and

Whereas, family members are often reluctant to accept a recommendation to terminate expensive therapies in terminal cases; therefore be it

RESOLVED, That the ISMA propose that hospital medical staffs, where appropriate, develop consultation teams to advise and recommend the continuation or cessation of therapy in difficult or possibly terminal cases when requested by the attending physician or family. The teams could consist of physicians in appropriate specialties, nurses, chaplains, administrators, etc.; and be it further

RESOLVED, That this resolution be introduced at the Interim 93 Meeting of the AMA by the Indiana Delegation.

RESOLUTION 93-14 Regulation of Electronic Signature Process

Introduced by: Indianapolis Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, "electronic signature" has become commonplace in most hospitals for physician convenience; and

Whereas, there are cost savings associated with electronic signature by speeding record completion and reducing the need for record storage awaiting physician signature as well as employee time to pull and refile those records; and

Whereas, most current systems do not allow for "on screen" or paper review of these documents prior to electronic signature; and

Whereas, even if "hard copy" were available for

■ resolutions

review, it is very unlikely that physicians would actually read the entire transcription prior to signature; and

Whereas, physicians are still responsible for statements signed by electronic signature; and

Whereas, physicians have the option not to use electronic signature by simply asking for their signature to be automatically affixed to the dictation; and

Whereas, if a copy of the actual transcription is presented to the physician more than a few days from the actual procedure or dictation, there may be poor recollection of actual details so that incorrect transcription may not even be recognized; and

Whereas, electronic signature rarely, if ever, impacts legal proceedings or malpractice outcomes; and

Whereas, treatment of major problems or surgical care is never rendered on the basis of dictated reports but rather is based on actual review of x-rays or specimens; and

Whereas, requiring signature of documents may delay transfer of patients to post hospital care; now therefore be it

RESOLVED, That the ISMA oppose the recent HCFA interpretation of regulation that mandates that all documents be visually reviewed prior to "electronic signature"; and be it further

RESOLVED, That this resolution be sent to the AMA 1-93 meeting in New Orleans in order to seek legislative action if needed to correct this misguided interpretation.

RESOLUTION 93-15 CLIA Legislation
Introduced by: District 4
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, CLIA regulations impact the ability of physicians to practice medicine, restricting diagnostic procedures that licensed physicians are qualified to do; and

Whereas, many of these diagnostic procedures are vital for diagnosis and treatment; and

Whereas, these procedures are more optimally done in the office of the physician; and

Whereas, the final regulations of the Clinical Laboratory Improvement Amendments have not waived these tests; and

Whereas, CLIA therefore interferes with the ability to practice efficient and superior medicine; there-

fore be it

RESOLVED, That the ISMA, in conjunction with the AMA, seek repeal of the CLIA legislation.

RESOLUTION 93-16 Medical Explorer Posts
Introduced by: Monroe/Owen County Medical Society, District 2
Referred to: Reference Committee 1
Action: Adopted as amended

Whereas, Resolution 89-19 passed, which resolved that the ISMA help develop and encourage the establishment of Medical Career Development Programs in high schools and universities throughout the state; and

Whereas, several Medical Explorer Posts have been established in various sites around the state; and

Whereas, there exists a need to continue encouragement and support for students who may choose medical careers; and

Whereas, there currently is no assistance being provided to these established Medical Explorer Posts; therefore be it

RESOLVED, That the ISMA reaffirm its position on Resolution 89-19; and be it further

RESOLVED, That the ISMA provide support from existing staff to these Medical Career Development Programs.

RESOLUTION 93-17 U.S. Surgeon General
Introduced by: Bernard Emkes, M.D.
Referred to: Reference Committee 1
Action: Adopted

Whereas, the physicians of America take the practice of medicine seriously; and

Whereas, issues affecting the medical care of the American public are best addressed by physicians; and

Whereas, President Clinton, through Donna Shalala, has appointed an interim Surgeon General, who is a nonphysician; now therefore be it

RESOLVED, That the ISMA express to the Congressional leaders of our state and other appropriate persons extreme displeasure with the choice of a non-physician as interim Surgeon General of the United States; and be it further

RESOLVED, That the ISMA, through the Indiana

delegation to the American Medical Association, make the entire U.S. Congress aware of this matter, as the appointment of a non-physician as interim Surgeon General is an affront to physicians and their patients nationwide.

RESOLUTION 93-18 Initial RMS Membership Dues

Introduced by: Resident Medical Society
Referred to: Reference Committee 4
Action: Adopted

Whereas, many residents and fellows who move into Indiana for continued training are not eligible for free membership in ISMA for the first six months (July through December) as are the senior medical students who have graduated from Indiana University School of Medicine; and

Whereas, there is presently no mechanism for incoming residents and fellows to join for the six months (July through December) of their first year in Indiana unless they are senior medical students who just graduated from IU School of Medicine; and

Whereas, the current mechanism used by ISMA results in residents and fellows who want to join ISMA immediately upon arriving in Indiana in July having to pay for one year of ISMA services but only receiving six months of ISMA services; and

Whereas, attracting increased membership for the Resident Medical Society would result in increased revenue for the ISMA; and

Whereas, increased membership at the RMS level results in additional delegates to the AMA; therefore be it

RESOLVED, That the ISMA waive the initial July through December membership dues for all incoming residents and fellows; and be it further

RESOLVED, That the ISMA, with the ISMA-RMS, send a letter to all incoming residents and fellows informing them of the opportunity to receive their initial resident membership free for the period of July through December of their moving into Indiana; and be it further

RESOLVED, That in addition, the ISMA implement as a one-year pilot project, starting Jan. 1, 1994, the adopted Resolution 92-44, which allows for a one-time membership fee for a resident's entire residency, so long as residency years are consecutive.

RESOLUTION 93-19

Introduced by:

Referred to:

Action:

CLIA Regulation Repeal

Indiana Dermatology Society,
Cleve Francoeur, M.D.,
Secretary

Reference Committee 3

Adopted Resolution 93-15 in lieu of Resolution 93-19

Whereas, the Clinical Laboratory Improvement Act (CLIA '88) attempts to regulate all laboratories in the state of Indiana regardless of size; and

Whereas, many Indiana physicians perform simple in-office laboratory procedures as part of the evaluation and treatment of their patients; and

Whereas, physicians are trained and licensed to perform these procedures and are already held to the standard of care under the Indiana Medical Malpractice Act regarding their performance; and

Whereas, Indiana patients benefit from the in-office testing performed by their physician; and

Whereas, the unreasonably burdensome requirements of CLIA are having no positive effect on the provision of quality laboratory services performed in physicians' offices and in some cases are forcing physicians to close their office labs or even seek early retirement; and

Whereas, CLIA therefore is actually interfering with the provision of medical care by Indiana physicians; now therefore be it

RESOLVED, That the ISMA work at both state and federal levels to seek repeal of the CLIA '88 regulation.

RESOLUTION 93-20 Family Violence - Amending the State Marriage License Application

Introduced by: ISMA Board of Trustees and ISMA Alliance

Referred to: Reference Committee 4

Action: Referred to Board of Trustees

Whereas, family violence has been named a major public health threat by the Centers for Disease Control; and

Whereas, violence touches as many as one-fourth of all American families; and

Whereas, between 2 and 4 million women each year experience violence by a partner and the number of battering injuries of women is greater than the total

■ resolutions

number of injuries sustained in car accidents, muggings and rapes combined; and

Whereas, family violence is the single largest cause of injury to women in the United States and accounts for

- One in seven women seen for general medical care in office practice,
- One in three women seeking care for any reason in hospital emergency rooms,
- One in four women who attempt suicide,
- One in four women who are pregnant, and
- More than half of the mothers of abused children; and

Whereas, the American Medical Association has launched a National Campaign Against Family Violence and the ISMA and the ISMA Alliance developed a state task force to educate physicians and the public about family violence; therefore be it

RESOLVED, That the ISMA and the ISMA Alliance actively lobby for the inclusion of a declaration on the state marriage license application that the laws of this state affirm the right of each applicant to live within the marriage free from violence and abuse and that physical abuse, sexual abuse, battery and assault of a spouse or other family member are violations and are punishable by state law.

RESOLUTION 93-21 Family Violence – Amending the State Birth Certificate

Introduced by: ISMA Board of Trustees and ISMA Alliance

Referred to: Reference Committee 4

Action: Referred to Board of Trustees

Whereas, family violence has been named a major public health threat by the Centers for Disease Control; and

Whereas, violence touches as many as one-fourth of all American families; and

Whereas, every year approximately 2 million children in the United States are seriously abused by their parents, guardians or others, and at least 1,000 children a year die as a result of their injuries; and

Whereas, child homicide is among the five leading causes of death in childhood; and

Whereas, studies suggest that approximately 20% of children will be sexually abused in some way before they reach adulthood; and

Whereas, survivors of childhood sexual abuse

often experience long-term effects upon their psychological and social well-being and may be more likely to be victimized in later life as well; and

Whereas, child victims of violence are more likely to perpetrate assaults and other aggression outside the family; therefore be it

RESOLVED, That the ISMA and the ISMA Alliance actively lobby for the inclusion of a declaration on the state birth certificate that the laws of this state affirm the right of each child to live free from violence and abuse, and that physical abuse, sexual abuse, battery and assault of a child are violations and are punishable by state law.

RESOLUTION 93-22 ISMA Recruitment Policies

Introduced by:

ISMA Membership Task Force

Referred to:

Reference Committee 4

Action:

Adopted

Whereas, it is critical that the ISMA speak with a unified voice, representing all physicians; and

Whereas, in order to be representative of all physicians, ISMA must count among its membership the many women, minorities and international medical graduates who serve the health care needs of this state; and

Whereas, the ISMA president's task force on membership has met to consider the needs of Indiana physicians who are women, minorities and international medical graduates; and

Whereas, the task force believes that inroads can be made in these important membership categories; therefore be it

RESOLVED, That ISMA enhance and effectively encourage participation of women physicians, minority physicians and international medical graduate physicians in all levels of the organization; and be it further

RESOLVED, That the ISMA reach out to women, minorities and international medical graduates by continuing to identify the membership needs of those physicians and striving to meet those needs; and be it further

RESOLVED, That the ISMA look to Indiana's medical students, residents and physicians in their early years of practice and work to recruit them into ISMA's membership.

RESOLUTION 93-23 Due Process, Fair Hearing & Release of Selection Criteria by Preferred Provider Organizations

Introduced by: Vanderburgh County Medical Society
 Referred to: Reference Committee 3
 Action: Adopted as amended

Whereas, preferred provider organizations offer a contractual arrangement whereby physicians who participate (or are invited to participate) are required to submit certain documentation of their credentials; and

Whereas, because of the contractual nature of the arrangement, preferred provider organizations are not required by law to release to physicians the criteria by which physicians are evaluated to determine whether or not the physician is denied or accepted by the preferred provider organization; and

Whereas, the physician has no recourse for denial of participation and the preferred provider organization is not required to provide a reason; therefore be it

RESOLVED, That the ISMA put forth a legislative initiative to require that any managed care entity that wishes to do business in Indiana be required by law to comply with the due process and fair hearing provisions of the Health Care Quality Improvement Act of 1986, and that all criteria used to determine a physician's acceptance by the managed care entity be released by the managed care entity to the physician or his/her representatives in advance of or simultaneously with any participation document distribution.

RESOLUTION 93-24A Retention of "Any Willing Provider" Language

Introduced by: Vanderburgh County Medical Society
 Referred to: Reference Committee 1
 Action: Adopted Substitute Resolution 93-24A

Whereas there has been a legislative effort to remove the "any willing provider" clause of the current preferred provider law in order to limit the number of physicians who are credentialed by preferred provider organizations; and

Whereas, the "any willing provider" clause is necessary to preserve patient choice of physicians; and

Whereas, the deletion of "any willing provider" language would create a situation where physicians could be prevented from accessing a patient base; and

Whereas, the deletion of "any willing provider" language could potentially result in physicians being denied for any reason; and

Whereas, patients may find themselves seeing physicians who may have been chosen for the cost rather than the quality of the care provided; therefore be it

RESOLVED, That the ISMA continue to vigorously oppose any attempt at deletion of the "any willing provider" clause from current Indiana law; and be it further

RESOLVED, That the ISMA support and promote the AMA policy on "any willing provider."

RESOLUTION 93-25 Support of AMA Anti-Trust Relief Efforts

Introduced by: Vanderburgh County Medical Society
 Referred to: Reference Committee 1
 Action: Adopted as amended

Whereas, the AMA has undertaken an effort for relief from some of the anti-trust laws with the Federal Trade Commission; and

Whereas, such laws effectively prevent the profession from safely accomplishing peer review and fee review; and

Whereas, health care reform may require that physicians form alliances outside of standard corporate structures in order to level the playing field; and

Whereas, negotiating with payors may become a very important activity for such groups or medical societies; therefore be it

RESOLVED, That the ISMA work diligently to support the efforts of the AMA to seek reform or relief of federal anti-trust laws.

RESOLUTION 93-26 Civil Immunity Law

Introduced by: George Underwood, M.D.
 Referred to: Reference Committee 3
 Action: Referred to Board of Trustees

Whereas, Indiana medical doctors and allied medical personnel have been volunteering their services at athletic events (especially at the high school

■ resolutions

level, i.e., football, basketball, soccer, etc.) with no remuneration; and

Whereas, it is difficult to find medical doctors and allied medical personnel to medically cover athletic events; and

Whereas, the Indiana law does not extend civil immunity to medical doctors or allied medical personnel who cover athletic events, thereby exposing them to malpractice claims; and

Whereas, the Civil Immunity Law passed in Indiana in 1987 specifically removes doctors and allied medical personnel from civil immunity status; therefore be it

RESOLVED, That the ISMA aggressively lobby the Indiana legislature to change the civil immunity statute IC 34-4-11.8.5 so it includes physicians and others registered, certified or licensed under IC 25.

RESOLUTION 93-27 Physician Laboratory Fee Reimbursement

Introduced by: Third District Medical Society
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, the cost for physicians, especially in solo or small practices, to comply with the Clinical Laboratory Improvement Amendments (CLIA) in their offices is significant. For example the cost for moderately complex laboratory is \$800 for registration, \$500 for inspection, and an annual fee of \$500 for proficiency testing, in addition to the increased cost for record compliance, etc.; therefore be it

RESOLVED, That the ISMA advocate that reimbursement for lab services reflect the true cost of services including the cost of compliance with government mandates.

RESOLUTION 93-28 Quality Lab Testing in Physician Offices

Introduced by: Third District Medical Society
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, the Indiana Department of Health is becoming more involved in the regulatory aspects of federal programs such as CLIA; and

Whereas, with the mandates from OSHA, CLIA and other government programs becoming increasingly complex; and

Whereas, physicians need assistance with the interpretation of various directives; therefore be it

RESOLVED, That the ISMA and the Indiana Department of Health form a committee to meet regularly to address and resolve concerns regarding the implementation of the mandates from OSHA, CLIA and other government programs (patterned after the Medicare and Medicaid coalition meetings that meet regularly).

RESOLUTION 93-29 Standardization of Managed Care Office Safety Standards

Introduced by: Indianapolis Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, medical practice is burdened with undue paperwork and bureaucracy, which adds substantially to medical care costs and competes with physicians' time for patient care; and

Whereas, we recognize and support the need for employers to ensure quality providers and quality facilities for their employees; and

Whereas, various existing agencies such as the Indiana State Department of Health, the Indiana State Fire Marshall and the Indiana Occupational Safety and Health Administration currently have standards for safety of physical plants, buildings and security of occupants of offices; and

Whereas, in the age of managed care there is an increasing growth of duplicate activities relative to safety standards within offices and their physical plants; therefore be it

RESOLVED, That the ISMA oppose redundant efforts at forming safety standards by individual managed care plans, and seek to limit managed care plans' quality assessment activities to matters of patient care and reimbursement; and be it further

RESOLVED, That the ISMA seek to have standardization and unification of such office review efforts as a means of reducing health care costs and unnecessary burdensome paperwork for health care providers and their employees; and be it further

RESOLVED, That the ISMA introduce this resolution to the Interim-93 meeting of the American Medical Association to seek appropriate legislative action.

RESOLUTION 93-30 Safety of Young Children
 Introduced by: Indianapolis Medical Society
 Referred to: Reference Committee 3
 Action: Adopted as amended

Whereas, part of our control of health care utilization must contain preventive measures; and

Whereas, injury prevention and control is an important part of prevention; and

Whereas, there have been many deaths from riding in open-bedded vehicles; and

Whereas, the majority of deaths in those cases have been children; and

Whereas, adults must be the providers of safety measures for children; therefore be it

RESOLVED, That the ISMA actively seek legislation that shall provide that no person under age 18 years be allowed to ride in the open bed of motorized vehicles on a public thoroughfare; and be it further

RESOLVED, That all persons riding in a covered vehicle have appropriate restraints to prevent injury.

RESOLUTION 93-31 Triplicate Prescriptions
 Introduced by: Indianapolis Medical Society
 Referred to: Reference Committee 3
 Action: Withdrawn at author's request

Whereas, there is no proof of any value of the triplicate prescriptions in enhancing the care of patients with pain; and

Whereas, the major value of the triplicate prescription program is intimidation of physicians from proper prescribing of opioids; and

Whereas, less than 7% of physicians have had any formal training in the assessment and treatment of pain prior to the institution of triplicate prescription programs; therefore be it

RESOLVED, That the ISMA actively seek legislation to prevent the initiation of any new triplicate programs or any monitoring system of physicians without first educating physicians in the proper prescribing of opioids; and be it further

RESOLVED, That the ISMA and all physicians in Indiana resist the implementation of any monitoring program that interferes with the interaction of the physician-patient relationship.

RESOLUTION 93-32 ISMA Membership for Physicians Practicing in Veteran Administration Hospitals
 Introduced by: Fort Wayne Medical Society
 Referred to: Reference Committee 4
 Action: Not adopted

Whereas, physicians who practice at the V.A. Hospital in Fort Wayne have indicated an interest in membership in the Fort Wayne Medical Society; and

Whereas, similar V.A. hospitals in other areas of Indiana may also have physicians who wish to join local medical societies; and

Whereas, V.A. physicians, because of their status as federal employees, do not believe that ISMA membership can assist them at the same level as independent or group practitioners; and

Whereas, the bylaws of the ISMA and local medical societies require a dual membership in both organizations; therefore be it

RESOLVED, That the ISMA establish a class of membership for V.A. physicians with a reduced dues structure, perhaps with some limitations on ISMA benefits, and permit local medical societies to also establish a separate membership class for this group of physicians if they so desire.

RESOLUTION 93-33 Membership Roster
 Introduced by: District 4
 Referred to: Reference Committee 4
 Action: Not adopted

Whereas, it is difficult to locate nonmember physicians who practice in different communities; therefore be it

RESOLVED, That the ISMA investigate the possibility of including non-ISMA members in the membership directory.

RESOLUTION 93-34 Statewide Managed Care Models
 Introduced by: Lake County Medical Society
 Referred to: Reference Committee 4
 Action: Adopted as amended

Whereas, managed care is a health care concept much in discussion; and

Whereas, in order to compete, physicians should

■ resolutions

maintain the widest alternatives possible; and

Whereas, the assistance of the ISMA to counties would be helpful; therefore be it

RESOLVED, That the ISMA support the concept of statewide professional consulting contracts and managed care models for use at regional and county levels in organizing and negotiating for managed care entities; and be it further

RESOLVED, That the AMA be the basis for authoritative information on that subject.

RESOLUTION 93-35 Promoting AMA Policy on "Any Willing Provider"

Introduced by: Lake County Medical Society
Referred to: Reference Committee 1
Action: Adopted Substitute Resolution 93-24A in lieu of Resolution 93-35

Whereas, PPOs and other similar forms of managed care are currently in vogue; and

Whereas, competition is the only consistently proven method of assuring high quality at lowest price; and

Whereas, physician access to all forms of practice must be encouraged to encourage competition; and

Whereas, many new forms of practice inconsistently advocate competition in care by limiting competition among care-givers; therefore be it

RESOLVED, That the ISMA support and promote the AMA policy on "any willing provider."

RESOLUTION 93-36 Patient Compensation Fund Surcharge

Introduced by: Lake County Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, there still remains a differential in the surcharge to the Patient Compensation Fund between two areas in Indiana; and

Whereas, administrative efforts have been pursued in the past to no avail; and

Whereas, the unfair discrimination in the differential continues; and

Whereas, the practice of low basic insurance rates without a fair payment into the compensation fund through the surcharge may result in an equally unfair

underfunding; therefore be it

RESOLVED, That the ISMA reinstate its past policy, renew its efforts regarding the issue of unfair differential in the Patient Compensation Fund surcharge and draft legislation if necessary to correct the discriminatory differences in the surcharge.

RESOLUTION 93-37 Sample Legislative Letters

Introduced by: Warrick County Medical Society
Referred to: Reference Committee 3
Action: Referred to Board of Trustees for report back to 1994 House of Delegates

Whereas, physicians' time is increasingly being encroached upon by bureaucratic regulations; and

Whereas, health care issues are becoming more crucial; and

Whereas, physicians need to become more responsive to legislative issues; therefore be it

RESOLVED, That the ISMA investigate ways to increase participation in the Key Contact Program.

RESOLUTION 93-38 Delegation of Physician's Responsibility to Paramedical Personnel

Introduced by: Elaine Hathaway, M.D., Indianapolis
Referred to: Reference Committee 1
Action: Referred to Board of Trustees

Whereas, many paramedical provider groups are attempting to broaden their scope of practice; and

Whereas, many of these groups are not adequately trained to perform all aspects of medical care; and

Whereas, the quality of care Indiana patients are receiving may be compromised; and

Whereas, some surgeons are delegating postoperative care to paramedical personnel not trained in surgical care; and

Whereas, the Medical Licensing Board has the authority to regulate a physician's delegation and supervision; therefore be it

RESOLVED, That the ISMA recommend to the Medical Licensing Board the adoption of the following language:

I. General Responsibilities of the Surgeon

The ultimate responsibility for diagnosing medical and surgical problems is that of the licensed doctor of medicine or osteopathy who is to perform the surgery. The operating surgeon is responsible for all surgical decisions and remains responsible for all treatment decisions. Preoperative evaluation and postoperative management, as well as the surgical procedure, constitute the practice of medicine.

II. Preoperative Responsibilities

The surgeon is responsible for preoperative evaluation of the patient, which includes: obtaining a review of the patient's history; performing an adequate preoperative exam; and making an independent diagnosis. In addition, it is the responsibility of the operating surgeon or an equivalently licensed doctor of medicine or osteopathy (or a physician practicing within a board-approved postgraduate training program) to explain the procedure to the patient and obtain informed consent. However, it is not necessary that the operating surgeon witness the signature of the patient on the written form evidencing informed consent.

III. Postoperative Responsibilities

The postoperative recovery period is defined as the length of time required to assure that the occurrence of complications from the surgery is minimal. Postoperative management is defined as all the treatment decisions made during the postoperative recovery period, as based upon the operating surgeon's personal observations and professional judgment. The postoperative responsibilities of the operating surgeon include, but are not limited to: 1) monitoring of the patient during the recovery process; 2) detecting and diagnosing conditions arising during the recovery process; 3) adjusting of medications; and 4) treating post-surgical complications.

The operating surgeon is responsible for the coordination of overall patient care during the postoperative period until the patient has recovered from the surgery.

IV. Delegation of Postoperative Responsibilities

The surgeon may delegate certain discretionary postoperative management activities to equivalently licensed doctors of medicine or osteopathy (or to a physician practicing within the board-approved postgraduate training program) under the following spe-

cific conditions:

A. Postoperative care may not be delegated to any other health care practitioner except under the direct on-premise supervision of the operating surgeon or equivalently licensed doctor of medicine or osteopathy (or to a physician practicing within a board-approved postgraduate training program).

B. If the surgeon is unable to personally render postoperative care due to an unusual event, such care must, when possible, be delegated by prearranged agreement with the patient. This care should be delegated to another equivalently licensed doctor of medicine or osteopathy (or to a physician practicing within a board-approved postgraduate training program).

C. All licensed physicians have a legal obligation to report instances of surgeons routinely delegating postoperative management to physicians with less training and surgical skills than the operating surgeon.

RESOLUTION 93-39 ISMA Training for County Officers

Introduced by:

Regino B. Urgena, M.D.,
Grant County Medical Society

Referred to:

Reference Committee 4

Action:

Referred to Board of Trustees

Whereas, health system reform will require intense grassroots participation in securing the interests of patients and physicians; and

Whereas, the county medical society officers (president, vice president or president-elect) are the appropriate administrators of the ISMA agenda at the county level; and

Whereas, the office of the president of the county medical society is the natural extension of the office of the president of the ISMA, and a close relationship would foster more effective teamwork in promoting ISMA initiatives statewide; therefore be it

RESOLVED, That the ISMA, through the office of the president, organize a seminar/workshop for county medical society officers in January or February of each year to accomplish the following objectives:

1. To enable the president and the ISMA to familiarize the county officers and delegates with ISMA programs and foster the spirit of teamwork;
2. To inform the county officers about the pressing issues confronting organized medicine and to

■ resolutions

educate them in the appropriate strategy for handling these issues;

3. To teach the county officers leadership and organizational skills in the areas of communication, lobbying, etc; and

4. To increase active participation statewide in physician advocacy as each year brings a new group of county officers to this seminar/workshop.

RESOLUTION 93-40 ISMA Health System Reform Plan

Introduced by: ISMA Health System Reform Task Force: Mike Mellinger, M.D., chairman; John Knote, M.D., co-chairman; George Branam, M.D.; Bernard Emkes, M.D.; Barney Maynard, M.D.; George Rawls, M.D.; and Fred Ridge, M.D.

Referred to: Reference Committee 4
Action: Adopted

Whereas, The ISMA Health System Task Force has expended a great deal of time and effort in preparing the ISMA Health System Reform Plan; and

Whereas, the ISMA desires to be proactive rather than reactive with regard to changes in Indiana's health care system; and

Whereas, the Clinton administration will be making numerous suggestions for change to the health care system; now therefore be it

RESOLVED, That the Indiana State Medical Association adopt the ISMA Health System Task Force Health System Reform Plan as the official position of the ISMA on health system reform.

RESOLUTION 93-41 Employer-Mandated Health Insurance

Introduced by: John D. MacDougall, M.D.
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, The AMA as one of its Health Access America proposals has called for an employer mandate requiring all employers to provide health insurance for all their employees; and

Whereas, Such a mandate would place an intoler-

able burden on small businesses nationwide; and

Whereas, Legislation has already been introduced in Congress that would achieve universal access by an individual mandate with the use of vouchers; therefore be it

RESOLVED, That the ISMA affirm its opposition to any proposed legislation calling for all employers to be totally responsible for the entire cost of health insurance premiums for their employees; and be it further

RESOLVED, That the Indiana delegation to the AMA submit a resolution to the I-93 meeting of the AMA House of Delegates asking that this also become policy of the American Medical Association.

RESOLUTION 93-42 Health Care Savings Account

Introduced by: John D. MacDougall, M.D.
Referred to: Reference Committee 2
Action: Adopted

Whereas, When Otis Bowen, M.D., was secretary of Health and Human Services, he favored the establishment of Health Care IRAs (medical savings accounts), but there was little legislative interest in that concept at that time; and

Whereas, Now legislation has been introduced in both houses of Congress to allow tax-deductible medical savings accounts; therefore be it

RESOLVED, That the ISMA affirm as policy its support of legislation allowing the establishment of tax-deductible Medical Savings Accounts; and be it further

RESOLVED, That the Indiana delegation to the AMA submit a resolution to the I-93 meetings of the AMA House of Delegates asking that this also become policy of the American Medical Association.

RESOLUTION 93-43 Opposition to a National Health Board

Introduced by: John D. MacDougall, M.D.
Referred to: Reference Committee 4
Action: Adopted

Whereas, The paramount goals of health system reform are to provide universal access at a reasonable cost; and

Whereas, To achieve these goals, the Clinton health plan purports to reduce costs due to excess

bureaucracy but in fact calls for an entire new bureaucracy headed by a seven-person national health board, which would assume control of one-seventh of our national economy for the executive branch of government; and

Whereas, Legislation has already been introduced in both houses of Congress that can achieve these goals without the executive branch usurping control of such a large segment of our economy; therefore be it

RESOLVED, That the ISMA affirm as policy its opposition to any proposed legislation that would place our entire health care system under a national health board; and be it further

RESOLVED, That the Indiana delegation to the AMA submit a resolution to the I-93 meeting of the AMA House of Delegates asking that this also become policy of the American Medical Association.

RESOLUTION 93-44 Change in District
Introduced by: Kosciusko County ISMA Members
Referred to: Reference Committee 2
Action: Adopted

Whereas, The members of the Indiana State Medical Association practicing in Kosciusko County currently are denoted as being in the 13th geographic medical district; and

Whereas, Physician members in Kosciusko County tend to participate in continuing medical education programs in Fort Wayne rather than South Bend due to their geographic location within the state; and

Whereas, It is difficult for Kosciusko County members to actively participate in the medical politics of the 13th District; now therefore be it

RESOLVED, That Kosciusko County be designated as a county within the 12th District; and be it further

RESOLVED, That the ISMA House of Delegates approve this geographic change; and be it further

RESOLVED, That this change become effective Jan. 1, 1994.

RESOLUTION 93-45 Physician Grassroots Political Action

Introduced by: William H. Beeson, M.D.,
ISMA president
Referred to: Reference Committee 2
Action: Adopted as amended

Whereas, Indiana physicians are keenly aware of the results when a successful grassroots lobbying campaign is undertaken by organized medicine political action committees. Examples of Indiana physicians' recent legislative successes are defense of the INCAP program, the defeat of the "sick" tax, preservation of the "any willing provider" and repeal of the triplicate prescription program; and

Whereas, IMPAC has been responsive to bipartisan physician input over the years. However, health system reform will require a renewed emphasis upon the election process; and

Whereas, Indiana physicians are confronting proposals to effect tremendous change in the way physician health care is delivered both at the state and national level; therefore be it

RESOLVED, That a select ad hoc committee of the ISMA Board of Trustees and the Executive Committee of the IMPAC Board be formed to undertake a thorough review of the overall membership of IMPAC, its organizational structure as compared to other political action committees, the level of integration of IMPAC activities with those of ISMA legislative activities and study its overall effectiveness and efficiency when compared to other states of the federation including IMPAC's relationship to AMPAC; and be it further

RESOLVED, That a "Dollar-A-Day" contribution program be developed with appropriate recognition for those ISMA and Alliance members who contribute to IMPAC.

RESOLUTION 93-46 Legal Counsel to Protect Physicians

Introduced by: Miami County Medical Society
Referred to: Reference Committee 2
Action: Not adopted

Whereas, Physicians have been the target of legal harassment as demonstrated by the recent case involving Dr. R.S. Farag of Peru, Ind., in Howard County Superior Court III; and

■ resolutions

Whereas, Indiana physicians need readily available legal assistance in this type of case; therefore be it

RESOLVED, That the ISMA: 1) retain permanent legal counsel to protect Indiana physicians from legal harassment; 2) investigate the specific Howard County incident involving Dr. Farag; 3) be readily available for all Indiana physicians as a resource for timely consultation and advice in these types of incidents; and 4) pursue legal malpractice cases against attorneys who resort to legal harassment and/or improperly handle cases against physicians.

RESOLUTION 93-47 Memorial Resolution to Honor Virginia Meade Wagner, M.D.

Introduced by: Indianapolis Medical Society

Whereas, Virginia Meade Wagner, M.D., served as an Indianapolis pediatrician and pediatric hematologist-oncologist, served as founder of Camp Little Red Door for children with cancer, served as founder of the Family Together Weekend for family members of children with cancer, served as medical director for Camp Riley for Handicapped Children and served as physician for Camp Superkids for children with asthma; and

Whereas, Virginia Meade Wagner, M.D., served as

president of the Little Red Door Cancer Agency, served as chairman of the board of the Visiting Nurse Service, served as the visiting physician at the Pleasant Run Children's Home and the Indiana Girls School; and

Whereas, Virginia Meade Wagner, M.D., served on the Indianapolis Medical Society Board of Directors, served as a delegate to the Indiana State Medical Association convention, frequently served as chair or member of a state convention reference committee and served as president of the Indiana Medical Licensing Board; and

Whereas, Virginia Meade Wagner, M.D., was the recipient of numerous awards including the Otis R. Bowen Physician Community Service Award and the Little Red Door Highest Honor Recognition Award; and

Whereas, Virginia Meade Wagner, M.D., served her profession, state and community with involvement, commitment, integrity and energy; therefore be it

RESOLVED, That Virginia Meade Wagner, M.D., be remembered by Indiana medicine as a compassionate and caring colleague whose influence during life was pervasive and whose influence, even after her death on July 14, 1993, will remain as constant, for having touched our world and the lives of Indiana physicians, patients and their families. □

Reference Committee members

Reference Committee 1

Reports of Officers, ISMA/AMA matters

Barney Maynard, M.D., chairman, Evansville
Alan Smith, M.D., Bedford
David Dersch, M.D., Muncie
Lana Patch, M.D., Huntington
Peter Petrich, M.D., Attica

Reference Committee 2

Constitution and Bylaws

Richard Pitman, M.D., chairman, Columbus
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Steve Perkins, M.D., Indianapolis
Jac Cooper, M.D., Valparaiso
William Pond, M.D., Fort Wayne

Reference Committee 3

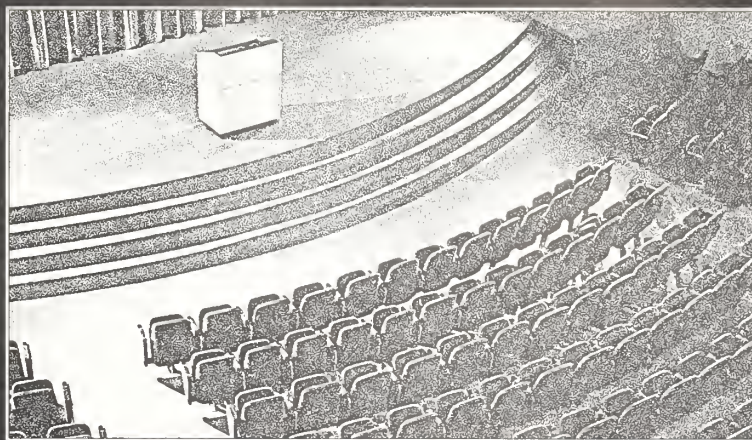
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John Pulcini, M.D., Evansville
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Stephen Tharp, M.D., Frankfort
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Reference Committee 4

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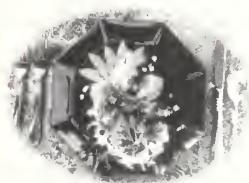
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ISMA Fifty Year Club



The Indiana State Medical Association honors 101 physicians this year in recognition of their 50 years of service as loyal and devoted practitioners of medicine. These new members of the Fifty Year Club will join the roster of other distinguished Hoosier physicians inducted into the Fifty Year Club since its inception in 1948.

The ISMA wishes to formally acknowledge the following physicians for their unselfish service to their patients and profession:

Frank B. Adney, M.D., Richmond
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 Forrest J. Babb, M.D., Mesa, Ariz.
 Charles Baran, M.D., South Bend
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 Kil C. Kim, M.D., Indianapolis
 Robert F. Kimbrough, M.D., Fort Wayne

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 John D. MacDougall, Indianapolis (1995)
 Michael O. Mellinger, LaGrange (1995)
 John A. Knote, Lafayette (1994)
 Shirley Khalouf, Marion (1994)
 George T. Lukemeyer, Indianapolis (1994)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

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 William Beeson, Indianapolis (1995)
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 C. Dyke Egnatz, Schererville (1994)
 Alfred Cox, South Bend (1994)

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 Secy: John Berry, Evansville
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 2 - Pres: Tom Sharp, Bloomington
 Secy: Robert Hongen, Bloomington
 Annual Meeting: May 12, 1994
 3 - Pres: Steve Barlow, Bedford
 Secy: Alan Smith, Bedford
 Annual Meeting: May 18, 1994
 4 - Pres: Barbara Taylor, Greensburg
 Secy: Angie Fontanilla, Greensburg
 Annual Meeting: May 4, 1994
 5 - Pres: James Walsh, Terre Haute
 Secy: Rahim Farid, Brazil
 Annual Meeting: May 26, 1994
 6 - Pres: William Toedebusch, Richmond
 Secy:
 Annual Meeting: May 11, 1994
 7 - Pres: Paula Hall, Mooresville
 Secy: John Schneider, Indianapolis
 Annual Meeting: to be announced

8 - Pres: Susan Pyle, Union City
 Secy: Jerome M. Leahey, Union City
 Annual Meeting: June 1, 1994
 9 - Pres: Irene Gordon, Lafayette
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 8, 1994
 10 - Pres: John L. Swarner, Valparaiso
 Secy: Anil Kothari, Valparaiso
 Annual Meeting: April 30, 1994
 11 - Pres: William D. Dannacher, Wabash
 Secy: Jack Higgins, Kokomo
 Annual Meeting: Sept. 14, 1994
 12 - Pres: Joseph Manthey, Bluffton
 Secy: Brenda Stiles, Fort Wayne
 Annual Meeting: Sept. 15, 1994
 13 - Pres: Alan H. Bierlein, Bristol
 Secy: John W. Schurz, South Bend
 Annual Meeting: March 23, 1994

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Consultant

Tom Martens, *Members Health Insurance*

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Endoscopic screening for colorectal cancer:

Recent studies from Indiana University

Douglas K. Rex, M.D.
Indianapolis

Increasingly, fecal occult blood testing is being recognized as an inadequate single screening measure for colorectal cancer. Although early studies in symptomatic patients with colorectal cancer indicated a sensitivity of 50% to 90% for fecal occult blood testing, recent studies in asymptomatic patients have found a sensitivity for cancer of only 30%.¹ The rate of gastrointestinal bleeding from colorectal cancers overlaps substantially with the amount of gastrointestinal bleeding that occurs in normal persons, creating an insurmountable limitation to the effectiveness of fecal occult blood testing. In addition, fecal occult blood tests essentially are useless in the detection of colonic adenomas.

Endoscopic screening and removal of adenomas, however, have been recently proven to reduce rectal cancer mortality. At the Indiana University Colorectal Cancer Screening Center, several studies have been performed that bear directly and fundamentally on basic issues in endoscopic screening for colorectal cancer. Many health care professionals and lay people in Indiana volunteered for and participated in

Abstract

Fecal occult blood testing is inadequate as a sole screening measure for colorectal cancer. Endoscopic screening and adenoma removal is now proven to reduce colorectal cancer mortality. At the Indiana University Colorectal Cancer Screening Center, studies have clarified several issues regarding endoscopic screening for colorectal cancer. Screening colonoscopy in 621 asymptomatic adults aged 50 to 75 years demonstrated that 27% had colonic adenomas. Increasing age and male gender were both powerful predictors of an increased prevalence of colonic adenomas. A family history of a single first-degree relative who developed colorectal cancer at age 60 or older did not predict a higher prevalence of colonic adenomas.

All cancers and all adenomas greater than or equal to 1 cm in size found in average-risk persons were found in persons aged 60 or older. Half of the people with adenomas had no neoplasia within reach of the flexible sigmoidoscope. Based on these findings, we have suggested that a single screening colonoscopy performed in average-risk persons in their early sixties may be an effective method to reduce colorectal cancer mortality.

In the screening colonoscopy study, distal colonic hyperplastic polyps were shown to not predict proximal colon adenomas. Therefore, colonoscopy is not warranted when only hyperplastic polyps are detected by flexible sigmoidoscopy in asymptomatic, average-risk people. Screening sigmoidoscopic exams using colonoscopes showed that 60 cm scopes have the optimal length for flexible sigmoidoscopy in unsedated patients. Finally, a screening colonoscopy study demonstrated that women with a personal history of breast cancer do not have an increased prevalence of colonic adenomas.

these trials as screenees. This article summarizes recently published results from these trials and places the results in the context of other recently published studies.

Colonoscopy in average-risk persons

More than 900 Indiana health care

professionals and their spouses volunteered for the screening colonoscopy study to determine the prevalence of colonic neoplasia in asymptomatic persons with negative fecal occult blood tests.^{2,3} Because of exclusions such as symptoms, risk factors and positive stool occult

blood tests, 621 persons aged 50 to 75 years were included in the final report, of whom 496 had no known risk factors for colorectal cancer (average risk) and 125 had a single first-degree relative with colorectal cancer or adenoma. Of 28 persons excluded from the study because of positive fecal occult blood tests, four had colorectal cancer. Of the 496 persons with average risk, 125 (25%) had at least one adenomatous polyp, and three had cancer.

Multivariate logistic analysis demonstrated both increasing age and male gender to be powerful predictors of adenomas (*Tables 1 and 2*). Fifty-one percent of those with adenomas and one person with cancer had no neoplasia distal to the sigmoid-descending colon junction. Thus, screening colonoscopy doubled the expected yield of flexible sigmoidoscopy. This impression is confirmed by analysis of the available literature on the yield of flexible sigmoidoscopy in asymptomatic persons, which demonstrates that on average 11% of asymptomatic

people undergoing sigmoidoscopy have an adenoma detected.²

While the original publication of the Indiana study was in press, another smaller study of screening colonoscopy in 89 asymptomatic, average-risk persons older than 50 also found a 25% prevalence of adenomas.⁴ Based on our results, we concluded that a single screening colonoscopy, performed on average-risk persons at about age 60, might be an effective strategy for reducing colorectal cancer mortality. The cost-effectiveness of this approach and mechanisms to reduce the cost of screening colonoscopy are under evaluation.

Influence of family history on prevalence of neoplasia

The Indiana study is the only controlled study using screening colonoscopy to examine the effect of family history on the prevalence of colonic neoplasia. A previous study using flexible sigmoidoscopy demonstrated that positive family history did predict a higher prevalence of adenomas.⁵ However, the results of several

uncontrolled studies⁶⁻¹⁰ of screening colonoscopy in persons with a family history of colorectal cancer indicated a prevalence of adenomas that was actually lower than that seen in uncontrolled trials of colonoscopy in average-risk persons (*Table 3*).^{2,4,11,12} The Indiana study examined the effect of a single first-degree relative with colorectal cancer. Multivariate logistic regression indicated that although increasing age and male gender were strong predictors of adenomas ($p<0.001$), positive family history was not ($p=0.29$) (*Tables 1 and 2*). This result confirms the conclusions of the recently published uncontrolled trials noted above. The conclusion does not apply to persons with a family history of multiple affected relatives. In addition, the Indiana study suggested that if the affected relative was younger than 60 at diagnosis, increased risk might be present. The study had insufficient power to answer this important question. Thus, persons with multiple affected relatives or relatives diag-

Table 1
**Number of subjects with colonic neoplasia
(cancer or \geq 1cm adenoma) by age, gender and family history***

	Age	50-54 yrs	55-59 yrs	60-64 yrs	65-75 yrs	All ages (total)
<u>Average risk</u>	Male	13/63 (21)	22/81 (27)	30/77 (39)	30/89 (34)	95/310 (31)
	Female	3/44 (7)	8/53 (15)	12/50 (24)	10/39 (26)	33/186 (18)
<u>Family history colon cancer</u>	Male	1/12 (8)	6/14 (43)	6/17 (35)	11/22 (50)	24/65 (37)
	Female	1/15 (7)	3/9 (33)	1/9 (11)	4/11 (36)	9/44 (20)

* Numbers denote subjects with neoplasia/subjects with designated age and gender, followed by the percentage in parentheses.

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nosed before age 60 may still be expected to have an increased prevalence of neoplasia detected at screening.

Importance of distal colonic hyperplastic polyps

Recently, controversy has surrounded the importance of distal colonic hyperplastic polyps detected at screening flexible sigmoidoscopy. It has been the standard of practice to perform colonoscopy on persons with adenomas detected at flexible sigmoidoscopy, since these persons were known to have a proximal colonic adenoma in about one-third of cases. Persons with only hyperplastic polyps in the distal colon have not undergone colonoscopy because they do not have an increased chance of proximal neoplasia. This issue is relevant only for distal polyps less than 6mm in size, since only these diminutive polyps have any significant probability of being hyperplastic. Biopsies of such polyps are necessary at the time of flexible sigmoidoscopy since hyperplastic polyps cannot be distinguished from adenomas on the basis of endoscopic appearance alone.

Controversy arose when several studies¹³⁻¹⁶ indicated that distal hyperplastic polyps were as predictive of proximal adenomas as were distal adenomas, indicating that all persons with diminutive polyps at flexible sigmoidoscopy should undergo colonoscopy. However, these studies were largely retrospective, performed in symptomatic patients or patients with occult blood in the stool, and did not contain control groups of people undergoing colonoscopy who had

Table 2			
Univariate and multivariate logistic regression analysis of effect of gender, age and family history of colorectal cancer on prevalence of colonic neoplasia (cancer or ≥ 1 adenoma) in 605 subjects*			
<u>Univariate analysis:</u>			
Variable	p-value	Odds ratio	95% CI†
Male/female	0.0002	2.08	(1.40 - 3.10)
Age (5-yr increase)§	0.0001	1.38	(1.19 - 1.60)
Family history colon cancer /average risk	0.34	1.25	(0.79 - 1.97)
<u>Multivariate analysis:</u>			
Variable	p-value	Odds ratio	95% CI
Male/female	0.0006	2.00	(1.33 - 3.00)
Age (5-yr increase)§	0.00004	1.36	(1.18 - 1.58)
Family history colon cancer /average risk	0.29	1.29	(0.81 - 2.06)
* Does not include 16 subjects with family history of colon polyp.			
† CI indicates confidence interval.			
§ Calculated for the effect of an increase in age of five years.			
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no polyp in the distal colon. Subsequently, two large prospective, controlled studies^{17,18} in symptomatic patients or patients with positive fecal occult blood tests (one of these studies was by a group that had found distal hyperplastic polyps to predict proximal adenomas in a retrospective study) found no increased prevalence of proximal adenomas in persons with distal hyperplastic polyps.

All of these studies had limited relevance to the hyperplastic polyp issue since they were performed in symptomatic patients or patients with positive fecal occult blood tests and these patients generally should undergo

full colonic evaluation in any case. The Indiana screening colonoscopy study is relevant to this issue since it was prospective, controlled and performed in the population in whom the question was relevant (asymptomatic, average-risk persons with negative fecal occult blood tests) and had sufficient size and statistical power to answer the question.¹⁹

The study showed that although people with distal colonic adenomas had an increased prevalence (38%) of proximal adenomas ($p < 0.001$), persons with distal hyperplastic polyps had a prevalence of proximal adenomas (18%) that was not different from the prevalence of proximal

Table 3

Uncontrolled trials examining the prevalence of neoplasia detected by colonoscopy in asymptomatic persons with average risk or with a positive family history (below not corrected for age or gender)

Average risk studies	Number of screenees	Prevalence adenomas	Cancers (number)
Johnson ¹¹	89	25%	0
Rex ¹⁰	210	25%	2
DiSario ^{12*}	119	41%	0
Lieberman ¹³	105	41%	0
Family history studies	Number of screenees	Prevalence adenomas	Cancers (number)
Grossman ¹⁸	108	13%	0
McConnell ¹⁹	125	12%	0
Guillem ²⁰	181	14%	0
Luchtefield ²¹	160	11%	0
Meager ²²	136	21%	1

* Men only

adenomas in persons with no distal polyps (15%) (Table 4). Thus, it is still appropriate to obtain biopsy samples of diminutive polyps found during flexible sigmoidoscopy in asymptomatic average-risk persons.

Optimal length of flexible sigmoidoscopes

A variety of flexible sigmoidoscopes has been commercially available, ranging from 35 cm to 130 cm in length. Shorter scopes were advocated for ease of use and longer scopes for increased yield. However, because of the tendency for longer scopes to bow in the sigmoid colon and a persisting slight leftward shift in the distribution of colonic neoplasms, increases in length were not accompanied by a propor-

tional increase in yield of neoplasms. To determine the optimal length of flexible sigmoidoscope, we performed screening flexible sigmoidoscopy in 500 asymptomatic persons using colonoscopes.²⁰ These 500 subjects were completely different persons from the volunteers who participated in the screening colonoscopy study described above.

We found that in unsedated persons with a sigmoidoscopy prep, the colonoscope was passed on average to only 66 cm on insertion and 55 cm after all bowing was removed. The number of polyps found above 60 cm increased the prevalence of neoplasia detected by only 1% (Table 5). As noted above, the yield of using colonoscopes is

much higher when the patient has a colonoscopy preparation and is sedated and total colonoscopy is performed.

The results suggested that during flexible sigmoidoscopy in an unsedated patient with a sigmoidoscopy preparation (in whom neither the patient nor the physician is expecting significant discomfort and with only a brief period of time scheduled for the examination), the physician is usually unwilling to produce the necessary pressure on the left colon (and resultant discomfort) to substantially advance the scope and use its full length. This study has largely settled the issue of optimal scope length for screening sigmoidoscopy in favor of 60 to 65 cm sigmoidoscopes.

Colonic adenomas in women with breast cancer

A variety of conditions or diseases has been associated with an increased risk of developing colorectal cancer. For some, the risk is well established: the polyposis syndromes, persons with previous colorectal cancers or large, dysplastic or villous adenomas and patients with longstanding ulcerative colitis. However, for other conditions, the degree of increased risk or even whether any increased risk is present has been uncertain.

One such condition is a history of breast cancer. Certain epidemiologic studies have indicated an increased lifetime risk of colorectal cancer in women with breast cancer. However, an enormous and well-designed cohort study in Sweden found no increased risk of colorectal cancer in these women.²¹ In addition, a recent case control study of

Table 4

Proximal colon findings according to distal colon findings in 482 asymptomatic average-risk subjects

Distal colon findings	PROXIMAL COLON FINDINGS				Total
	No polyps	Adenoma	Hyperplastic polyps only	Cancer	
No polyps	307 (81)*	58 (15)	11 (3)	1	377
Adenoma	34 (59)	22 (38)	2 (3)	0	58
Hyperplastic polyps only	33 (73)	8 (18)	4 (9)	0	45
Cancer	2	0	0	0	2

Note: Proximal is defined as proximal to the sigmoid-descending colon junction, and distal is defined as distal to this same junction.

* Figures in parentheses indicate the percentage of subjects.

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women who had undergone colonoscopy found no increase in the prevalence of colonic adenomas in women with a history of breast cancer.²² Three of four cross-sectional prevalence studies using flexible sigmoidoscopy found an increased prevalence of colonic adenomas in women with breast cancer.^{23,26}

However, serious bias and methodologic flaws were present in some of these studies. Thus, careful examination shows that of the three positive studies, one²³ is actually negative after bias is removed, and another²⁴ showed only a higher prevalence of adenomas less than 3 mm in size in the breast cancer patients. In this study, 77% of polyps less than 3 mm were adenomas. This raises concern about the pathologic evaluation of the polyps, since other studies have

shown that polyps must be 4 mm in size before there is a 50% probability of the polyp's being an adenoma.²⁷ If polyps only greater than 3 mm are considered, this study²⁴ is also negative. Thus, there is considerable doubt, based on analysis of previous literature, whether women with breast cancer have either an increased lifetime risk of colorectal cancer or an increased prevalence of colonic adenomas.

The first study²⁸ to examine the prevalence of colonic neoplasia in women with breast cancer using colonoscopy was performed in conjunction with the Indiana colonoscopy screening trial. Pat Harper, M.D., of the Indianapolis Breast Center collaborated with us in recruiting breast cancer patients who were asymptomatic from a gastrointestinal standpoint. The study was tightly controlled for all known

risk factors for colorectal cancer, for asymptomatic status and for fecal occult blood test results. Thus, the breast cancer patients and the control women were similar in all regards except their history of breast cancer.

One-hundred ninety-three women with breast cancer participated, and 186 asymptomatic average-risk women were available from the screening colonoscopy study for comparison. Multivariate logistic regression indicated that both increasing age and body weight were predictive of colonic adenomas. However, the prevalence of colonic adenomas in the breast cancer patients aged 50 to 75 years with breast cancer as their only potential risk factor was identical (18%) to the prevalence in the average-risk women. We concluded that women with breast cancer have a prevalence of colonic adenomas that is the same

as average-risk women and that they should undergo the same colorectal cancer screening measures.

Summary

Studies conducted at the Indiana University Colorectal Cancer Screening Center have demonstrated that increasing age and male gender are the best predictors of the presence of colonic adenomas. A positive family history of a single first-degree relative with colorectal cancer is not predictive, although this may not be true if the affected relative was younger than 60 years of age at diagnosis. The results suggest that a single screening colonoscopy performed on aver-

age-risk individuals in their early 60s might be an effective strategy for reduction of colorectal cancer mortality. In addition, distal hyperplastic polyps do not predict proximal adenomas. The optimal length for flexible sigmoidoscopes is 60 to 65cm. Women with breast cancer history have the same prevalence of colonic neoplasia as average-risk women. □

The author is with the Division of Gastroenterology/Hepatology, Department of Medicine, at the Indiana University School of Medicine in Indianapolis.

Correspondence and reprints: Douglas K. Rex, M.D., Indiana Uni-

versity Hospital, Room 2300, 550 N. University Blvd., Indianapolis, IN 46202.

The author would like to thank all the health care professionals and lay people in Indiana who have increased our understanding of colorectal neoplasia through their participation in these studies.

The following references report studies performed at the Indiana University Medical Center. The complete list of references is available by writing to INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202.

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Table 5

Location of the most distal polyp detected in 87 subjects with polyps detected at flexible sigmoidoscopy performed with colonoscopes

Distance (cm)	Number	Percentage
0-10	26	30
10-20	32	37
20-30	10	11
30-40	7	8
40-50	5	6
50-60	3	3.5
60-120	4	4.5
Total	87	100

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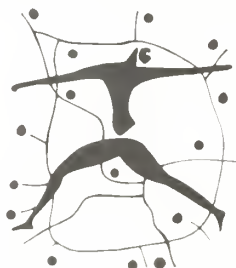
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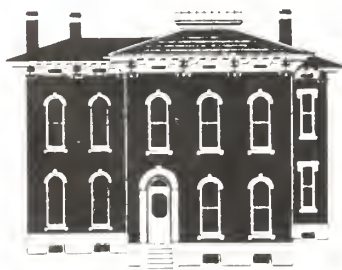


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■ alliance report

**Sue Ellen Greenlee, ISMA
Alliance president
Lucy Reed Foltyniak,
corresponding secretary**

Mark your calendars for Feb. 25 through 27 – the weekend we've been waiting for! The ISMA and the ISMA Alliance will sponsor a marriage enrichment weekend for physicians and spouses.

What kind of event is this? It's a weekend workshop, organized by Candace Backer, ISMA physician assistance coordinator, designed to strengthen your marriage, improve communication and address common problems such as stress, lifestyles and children. The workshop also will address specific problems of medical marriages. It provides an opportunity to have fun with your spouse, spend time together, recharge and reconnect.

The workshop will be held at the Howard Johnson-Plaza Hotel in Lafayette, Ind. Registration begins Friday evening, and a speaker will follow from 8 p.m. to 9 p.m. The workshop will conclude at noon Sunday after a morning presentation. The registration fee is \$250 per couple, which includes speaker fees, programs and Saturday's meals.

The Marriage Enrichment Weekend is the best gift you could give your spouse and your marriage.

Other Alliance activities
The ISMA Alliance now offers

two new brochures for distribution. "Widow-Widowers Support Network" or "SOS" (Spouses Offering Support), contains information concerning our confidential telephone helpline. The other brochure, "Help and Hope," contains information about another helpline offering confidential support to medical families affected by substance abuse or marital stress. The pamphlets are available by calling your county Alliance or Rosanna Iler at the ISMA, (317) 261-2060 or 1-800-257-4762.

Eight ISMA Alliance members will attend Confluence II in Chicago Jan. 30 through Feb. 1. For

the first time, a resident spouse, Leslie Shevlin of Delaware-Blackford County, will participate. Other attendees include: Cindy Klee, Allen County; Cindy Andreason, Vigo County; Jeanne Houck, LaPorte/Michigan City; Julie Hampton and Lynn Brazel, Madison County; Laurel Weddle, Bartholomew/Brown County; and Ann Silberman, Porter County.

Brenda Willis, membership secretary of the Indianapolis Medical Society, also will participate. Representing the medical society, she will experience firsthand the training we give to our leaders. □

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County	President	Spouse
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Elkhart	Barbara Piaskowy	Frank
Floyd	Denise Gardner	Richard
Fort Wayne/Allen	Marcia Laker	Gene
Grant	Rhonda Mueller	Arndt
Howard	Penni Gard	Richard
Indianapolis	Sharon Gilmor	Richard
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Lake	Karen Brown	John
LaPorte/LaPorte	Nancy McGill	Charles
LaPorte/Michigan City	Betty McDonald	Eugene
Noble/LaGrange	Lura Stone	Robert
Madison	Julie Hampton	Stephen
Monroe/Owen	Sharon Cofield	Dean
Porter	Nancy Kelley	William
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■ from the museum

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Italian psychiatrists Ugo Cerletti (1877-1963) and Lucio Bini (1908-1964) introduced electroconvulsive therapy (ECT), or shock therapy, in 1938 as the newest treatment for severe mental illnesses, such as schizophrenia.

The appearance of electroconvulsive therapy lessened the use of earlier treatments for schizophrenia, such as insulin shock therapy and Metrazol shock therapy. These treatments were introduced during the early 1930s by Viennese psychiatrist Manfred Sakel (1900-1957) and Hungarian psychiatrist Ladislav von Meduna (1896-1964), respectively.

Insulin shock therapy required the physician to intramuscularly administer increasing daily doses of insulin until the patient fell into a coma. After a half hour to an hour, the physician administered a dextrose solution to restore the sugar loss.

A convulsion would occur almost immediately with the intravenous injection of Metrazol, a derivative of camphor. After the convulsion, the patient experienced a brief period of dread and confusion and then succumbed to a relaxed sleep.

By the late 1940s, electroconvulsive therapy replaced the use of these other treatments. Electroconvulsive therapy required giving the patient a series of electric shocks across the temples of sufficient intensity (usually between 70 to 130 volts) to produce a convulsion. The convulsion usually lasted one minute, after which the patient typically remained unconscious for about half an hour.

Dementia Praecox - The Past

Decade's Work and Present Status: A Review and Evaluation (1947), an exhaustive survey of the accumulated literature, extensively described and compared the procedures for and the effectiveness of electroconvulsive therapy and the other treatments for schizophrenia that physicians had employed since the middle 1930s.

Since electroconvulsive therapy apparently effected improvements in some patients, numerous theories that attempted to explain this effectiveness were developed in order to provide the rationale desired for the therapy's continued use. However, the abundance and equal plausibility of these theories subsequently indicated that a definitive explanation did not exist.

After the late 1950s, electroconvulsive therapy was discontinued since the procedure had not

proved unequivocally effective in treating schizophrenia. In addition, the introduction of chlorpromazine and other antischizophrenic drugs during the 1950s had provided physicians with other treatment alternatives. Today, electroconvulsive therapy is used primarily in cases of severely depressed patients who fail to respond to other treatments.

"The Worlds of John Zwara," the current exhibit at the Indiana Medical History Museum in Indianapolis, examines the various treatments for schizophrenia during the last two centuries. The exhibit explores the life and works of watercolor artist John Zwara, who suffered from schizophrenia.

For more information, call the museum at (317) 635-7329. □

The author is the director of the Indiana Medical History Museum.



Electroconvulsive therapy required giving the patient a series of electric shocks across the temples of sufficient intensity to produce a convulsion. The convulsion usually lasted one minute, after which the patient typically remained unconscious for about half an hour.

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■ cme calendar

Indiana University

The Indiana University School of Medicine will sponsor these courses:

- Feb. 12-13-** Annual Meeting of the Indiana Academy of Anesthesiology and Anesthesia Update, The Westin Hotel, Indianapolis.
- Mar. 11** - Infections in the Central Nervous System, University Place Conference Center, Indianapolis.
- Mar. 13-15-** 1994 Symposium on Breast Imaging, University Place Conference Center, Indianapolis.
- Apr. 8-9** - Thoracoscopy for the Chest Physician, University Place Conference Center, Indianapolis.
- Apr. 21-22-** 17th Annual Arthur B. Richter Conference in Child Psychiatry, University Place Conference Center, Indianapolis.
- Apr. 28** - Gastroenterology Update 1994, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology in Indianapolis will present "Echocardiography 1994: Practical Applications for Clinicians" March 4 at The Ritz Charles in Carmel.

For more information, call Janet MacAbee, (317) 871-6089.

Methodist Hospital

Methodist Hospital of Indiana in Indianapolis will sponsor these CME courses:

- Jan. 29** - Clinical Echocardiography, site to be announced.

- Mar. 5** - Cardiology Update, University Place Conference Center, Indianapolis.

For details, call (317) 929-3733 or 1-800-847-3370.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will present its annual G.I. seminar, "The Liver," March 3.

For more information, call (812) 479-4468.

Reid Hospital & Health Care

Reid Hospital & Health Care Services in Richmond will sponsor the "Fourth Annual Pediatric Seminar" Feb. 17.

For more information, call Marie Hopper, (317) 983-3112.

University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Feb. 27-** Practical Aspects of Radiology and Imaging, Marriott's Camelback Inn, Scottsdale, Ariz.
- Mar. 3**
- Mar. 3-6** - The Multimodality Treatment of Breast Cancer, Pinehurst Resort and County Club, Pinehurst, N.C.

For more information, call (313) 763-1400.

Ohio State University

The Ohio State University Center for Continuing Medical Education will sponsor these CME courses:

- Feb. 12** - Infectious Diseases, Hyatt on Capitol Square, Columbus, Ohio.

- Mar. 4-5** - 37th Annual Postgraduate Symposium in Ophthalmology: Diagnostic Pathology, Hyatt on Capitol Square, Columbus, Ohio.

- Mar. 20-25-** Third Annual Cardiovascular Disease: The High-Risk Patient: An Interspecialty Approach, Snowmass-Bedford Conference Center, Snowmass-Aspen, Colo.

For more information, call Sandi Latimer, (614) 293-3660.

Chicago Medical Society

The Chicago Medical Society will present the 50th Annual Midwest Clinical Conference Feb. 11 through 13 at the Sheraton Chicago Hotel.

The conference is coordinated by the Chicago Medical Society with the help of 43 specialty societies and associations.

For more information, call (312) 670-2550.

George Washington University

The George Washington University Medical Center will sponsor these CME courses:

- Feb. 1-5** - 19th Annual Meeting of the Alliance for CME, Hotel del Coronado, San Diego, Calif.
- Mar. 6-11** - Update in Clinical Medicine, The Radisson, Vail, Colo.
- Mar. 18** - Ultrasound in Abdominal Surgery, The George Washington University Medical Center, Washington, D.C.

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■ news briefs

ISMA plans marriage enrichment weekend

Physicians and spouses are invited to attend a marriage enrichment weekend sponsored by the Indiana State Medical Association and the ISMA Alliance. "The Medical Marriage: Strengthening Couples' Ties to Each Other" is the theme of the workshop, to be held Feb. 25 to 27 at the Howard Johnson Plaza Hotel in Lafayette.

The event is designed to help couples improve their communication skills, identify their strengths as a couple, understand how their family of origin impacts them as a couple and learn more about their parenting styles.

Sessions will include the following topics: "Having Fun in Your Marriage - How Important Is It?" "Conflict Resolution," "Raising Your Children - Raising Yourself," "Increasing Effectiveness in Couple's Communication," "Passion in Your Marriage" and "Parenting in the '90s."

Speakers will be Candace Backer, ACSW NCAC II, ISMA physician assistance coordinator; Diane Brashear, Ph.D., clinical assistant professor in the Department of Obstetrics and Gynecology at the Indiana University School of Medicine; George Brenner, M.S., addictions coordinator for Gallahue Mental Health Center in Indianapolis; Judy Meyers-Walls, Ph.D., associate professor in the Child Development and Family Studies Department at Purdue University; Pat Murphy, Ph.D., psychologist for Gallahue Mental Health Center in Greenfield; Kathy O'Brian-Christoff, M.S., assistant director of continuing care at Quinco Consulting Center in Columbus, Ind.; and Riette Smith, M.S., in private practice in Bloomington, specializ-

ing in marriage and family therapy.

The workshop will open Friday, Feb. 25, with registration from 5 p.m. to 8 p.m. and conclude at noon Sunday, Feb. 27. The \$250 fee per couple includes all meals on Saturday, all conference sessions, breaks and materials.

The registration deadline is Feb. 7. For more information, call Candace Backer at the ISMA, (317) 261-2060 or 1-800-257-4762.

Hotel reservations may be made by calling the Howard Johnson's, (317) 447-0575.

Conference focuses on violence prevention

A conference on "Children/Teens/Guns/Violence: Taking Action Together, Now" will be held Jan. 20 at University Place Conference Center in Indianapolis. Physicians, other professionals and community leaders interested in reducing violence and preventing firearm-related injuries to children are invited.

Speakers will include Katherine Christoffel, M.D., attending physician in general academic and emergency pediatrics at Children's Memorial Hospital in Chicago, and Jay Winsten, Ph.D., associate dean and director of the Center for Health Communication at the Harvard School of Public Health.

The registration fee is \$60, which includes parking, lunch and materials. For conference information, call (317) 274-2964. For registration information, call (317) 274-4364.

Indiana doctor helps Romanian colleague

An Indianapolis ophthalmologist teamed up with Tissue Banks

International in Baltimore, Md., to save the sight of a Romanian ophthalmologist.

William E. Whitson, M.D., co-director of Corneal Consultants of Indiana, performed a corneal transplant at St. Vincent Hospital in Indianapolis to restore the vision of Dr. Paul-Ioan Grecu, who practices at the Clinical Hospital of Ophthalmology in Bucharest. Dr. Grecu, in the United States on a fellowship to study the American health care delivery system, had lost the sight in his left eye as the result of a severe viral infection.

Because Dr. Grecu's insurance did not cover the procedure and he could not afford to pay for the transplant, Dr. Whitson performed the surgery and follow-up exams at no charge. Tissue Banks International covered the cost of recovering the eye tissue, testing it and transporting it to Indianapolis.

Dr. Whitson said Dr. Grecu's prognosis is excellent and normal vision is expected to be restored in about six months.

Medical school launches capital campaign

The Indiana University School of Medicine is conducting the first capital campaign in the 90-year history of the school. Pledges and gifts of more than \$52 million toward the \$130 million goal have already been received.

Major gifts so far include \$7 million from Eli Lilly and Co. and the Eli Lilly and Co. Foundation, \$3 million from The Delany Trust and \$12.1 million from the James Whitcomb Riley Memorial Association. Campaign funds will be used for new construction, endowments and research. □



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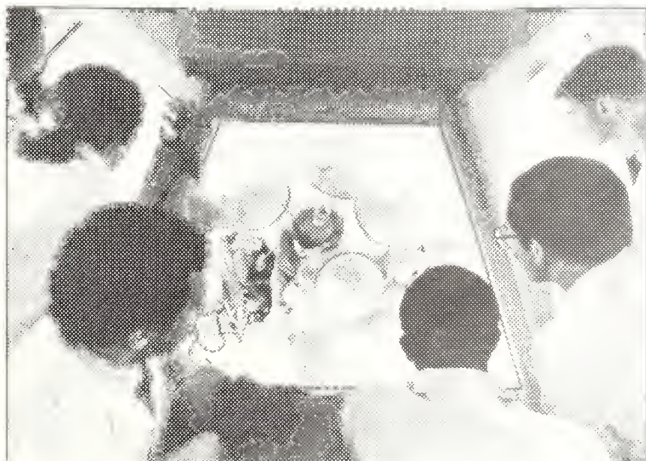
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■ obituaries

James E. Albright, M.D.

Dr. Albright, 45, a Fort Wayne orthopaedic surgeon, died Aug. 26, 1993, in his home.

He was a 1972 graduate of the Indiana University School of Medicine.

Dr. Albright was affiliated with Orthopaedics Northeast and served as president of the medical staff at Parkview Memorial Hospital in 1989. He was a member of the Fort Wayne Orthopaedic Society, the Mid-America Orthopaedic Society and the American Academy of Orthopaedic Surgeons.

Joseph E. Ball, M.D.

Dr. Ball, 85, a retired Indianapolis general practitioner, died Oct. 12, 1993, in Wildwood Nursing Home.

He was a 1940 graduate of the Indiana University School of Medicine and an Army Air Corps veteran.

Dr. Ball retired in 1985, after 39 years in practice. He was once named Distinguished Physician by the staff of Community Hospital.

Edward A. Campagna, M.D.

Dr. Campagna, 76, formerly of East Chicago, died Nov. 8, 1993. He was living in San Carlos, Calif., at the time of his death.

He was a 1939 graduate of the Loyola University Stritch School of Medicine and an Army veteran of World War II.

Dr. Campagna practiced in East Chicago for more than 50 years, retiring in 1991. He had served as health officer and school physician for the city of East Chicago for more than 20 years and was a former chief of staff at St. Catherine Hospital. He was a member of the American College of Surgeons.

Dale D. Dickson, M.D.

Dr. Dickson, 86, a retired Greensburg general physician, died Oct. 27, 1993.

He was a 1932 graduate of the Indiana University School of Medicine. An Army Air Corps veteran of World War II, Dr. Dickson received the Legion of Merit for designing a modification of the B-29 tail gunner's compartment to permit easy removal of a wounded crewman.

He was a physician in Decatur County for more than 52 years. He was an ordained deacon at the First Baptist Church in Greensburg and had participated in three missions to Haiti and one to Africa. Dr. Dickson was named a Sagamore of the Wabash in 1979. He served 40 years with the Boy Scouts.

Roy A. Geider, M.D.

Dr. Geider, 91, a retired Indianapolis general practitioner, died Oct. 8, 1993. He was a resident of Ann Arbor, Mich., at the time of his death.

He was a 1927 graduate of the Indiana University School of Medicine. An Army veteran of World War II, Dr. Geider received seven battle stars.

He retired in 1982, after 37 years as a general practitioner. In 1986, he received the Distinguished Physician Award from Community Hospital, where he was on the board of trustees. He was past president of medical staffs at Methodist and Community East hospitals.

William A. Gitlin, M.D.

Dr. Gitlin, 82, a retired Bluffton family physician, died Sept. 1, 1993, at Lutheran Hospital in Fort Wayne.

He was a 1935 graduate of the

Indiana University School of Medicine and received five battle stars while serving with the Army during World War II.

After the war, Dr. Gitlin returned to Bluffton, where he practiced until his retirement in 1990. During his medical career, he delivered more than 2,000 babies and held the posts of city health officer, county health officer, county home physician, county jail physician and county coroner. He served several terms on the school board and two terms as a director of the National School Board Association. He received numerous awards, including the Community Service Award, the Outstanding Citizen of the Year Award from the Bluffton Chamber of Commerce and the Sagamore of the Wabash Award.

Richard C. Haller, M.D.

Dr. Haller, 71, a retired Fort Wayne neurologist, died Aug. 30, 1993, in St. Joseph Medical Center in Fort Wayne.

He was a 1953 graduate of the Indiana University School of Medicine and a veteran of World War II.

Dr. Haller had been on the staffs of Parkview Memorial Hospital and St. Joseph Medical Center.

James C. Katterjohn, M.D.

Dr. Katterjohn, 75, a retired Indianapolis radiologist, died Oct. 22, 1993.

He was a 1942 graduate of the Indiana University School of Medicine and served in the Army Medical Corps.

Dr. Katterjohn retired in 1984, after 40 years in private practice and in affiliation with St. Francis Hospital Center. At St. Francis, he had been chairman of the radi-

ology department, president of the medical staff and a member of the advisory board. He received a distinguished service award from the medical staff in 1960. Dr. Katterjohn was a fellow of the American College of Radiology and served on the Radiation Control Advisory Commission under former Gov. Otis R. Bowen.

Richard N. Kent, M.D.

Dr. Kent, 82, a retired Fort Wayne internist, died Sept. 18, 1993, in Parkview Memorial Hospital in Fort Wayne.

He was a 1937 graduate of Northwestern University Medical School and an Army veteran of World War II.

Dr. Kent practiced at the Mayo Clinic in Rochester, Minn., from 1941 to 1946 and in Fort Wayne from 1946 to 1987. He then was a medical consultant to Medical Protective until 1992. He was a member of the Indiana Society of Internal Medicine.

Walter A. Repay, M.D.

Dr. Repay, 72, a Hammond family physician, died Oct. 5, 1993.

He was a 1960 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Repay practiced in the Calumet area for 33 years. He had served as president of the St. Margaret Hospital medical staff and was one of the founding members of the St. Margaret Renal Dialysis Center. He was the Gavit High School team doctor for 22 years.

Jaime A. Salomon, M.D.

Dr. Salomon, 71, a retired Indianapolis family physician, died Oct. 24, 1993.

He was a 1946 graduate of the University of the Philippines College of Medicine.

Dr. Salomon retired in 1990, after more than 40 years in private practice. He was a member of the American College of International Physicians.

Noshir R. Toddywalla, M.D.

Dr. Toddywalla, 42, a urological surgeon in Dearborn County, died Nov. 11, 1993.

He was a 1973 graduate of the University of Bombay, India.

Dr. Toddywalla was the chief of the medical staff of Dearborn County Hospital in Lawrenceburg and immediate past president of the Dearborn-Ohio County Medical Society.

Robert C. Ziss, M.D.

Dr. Ziss, 68, a retired Evansville internist and member of the INDIANA MEDICINE editorial board, died Nov. 3, 1993, at his home.

He was a 1950 graduate of the Northwestern University Medical School and was a medical officer in the Navy, serving in World War II and the Korean War.

Dr. Ziss, who specialized in the treatment of diabetes, was a member of the American Diabetes Association, the American Society of Internal Medicine and the International Diabetes Foundation. He was a member of the Travelers' Century Club, which required members to have visited at least 100 countries. □



Dr. Beeson

Dr. William H. Beeson, an Indianapolis facial plastic and reconstructive surgeon, was elected to a six-year term on the American Board of Facial Plastic and Reconstructive Surgery. In other activities, he was the only faculty member in a week-long course for the Australian Society of Otolaryngology – Head and Neck Surgery and recently completed a new textbook on rhytidectomy for W.B. Saunders Co. titled *Facial Plastic Surgery Clinics of North America – Facelift*. He was the guest editor for the textbook and authored two chapters, "Selection of Successful Candidates for Rhytidectomy Surgery" and "Extended Posterior Rhytidectomy."

Dr.

Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was installed as secretary of the American Academy of Facial Plastic and Recon-



Dr. Perkins

structive Surgery; he will serve a four-year term. He recently taught courses on chemical face peeling and transconjunctival blepharoplasty at the annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery in Minneapolis. Dr. Perkins and his colleagues from the Meridian Plastic Surgery Center, **Dr. A. Michael Sadove** and **Dr. William R. Nunery**, led pro-

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

September

Brown, Randall D., Seymour
Cook, Thomas L., Evansville
Cooperman, Alan S., Fort Wayne
Dones, Antonio B., Fort Wayne
Gabrys, G. Thomas, Fort Wayne
Hazen, Mark S., Fort Wayne
Jardenil, Romulo S., West Lafayette
Lauer, Dean H., Valparaiso
Lawton, Dennis F., Muncie
Leon, Mario, Jasper
Merkle, George W., Bluffton
Patel, Shodhan L., Merrillville
Rex, Douglas K., Indianapolis
Sandock, Mark S., South Bend
Steinmetz, C. H., Indianapolis
Winters, Peter L., Indianapolis
Ziperman, Don B., Indianapolis

October

Babcock, George K., Bluffton
Barrett, Warrick L., Lafayette
Beckley, Kenneth W., Zionsville
Daftary, Mostafa, Greensburg
Dickerson, Gregg A., Muncie
Eliades, Anne, Muncie
Fiacable, Joseph P., Fort Wayne
Franks, Charles D., Newburgh
Frick, Fred W., Indianapolis
Gabovitch, Edward R., Indianapolis

Givens, Stanley S., Carmel
Greenwood, Charles W., Columbus
Greico, Vincent M., Elkhart
Hathaway, Elaine G., Indianapolis
Herring, Malcolm B., Indianapolis
Hilton, David K., Evansville
Howerton, Daniel M., Jeffersonville
Jackson, Richard W., Beech Grove
Johnson, William V., Corydon
Johnston, Richard M., Fort Wayne
Krueger, James R., Evansville
Kubley, Rod S., Plymouth
Larson, Michael S., Munster
Lyons, Charles R., Wabash
Markstone, David H., Indianapolis
Mason, Lester M., Terre Haute
Naum, Chris C., Carmel
Park, Ben H., Lebanon
Pitts, Neal C., Bluffton
Prevel, Christopher D., Carmel
Ramirez, Jose L., Munster
Scherschel, Kim P., Bedford
Seidle, Michael E., Muncie
Sellers, Francis M., South Bend
Sepehri, Bahram, New Albany
South, Dale R., Elkhart
Stein, Mark H., Indianapolis
Thong, Siong-Hoat, Fort Wayne
Waksman, Alberto, Bluffton
Wanner, Loren J., Bluffton

grams at the "New Frontiers in Facial Plastic and Reconstructive Surgery" seminar sponsored by the Indiana University School of Medicine Department of Otolaryngology-Head and Neck Surgery. Dr. Perkins was also a co-director of the seminar.

Dr. Frederick M. Kelvin, an Indianapolis radiologist, spoke on anal ultrasonography and evacuation proctography during a con-

ference on pelvic floor disorders at Rush-Presbyterian St. Luke's Medical Center in Chicago.

Dr. Steven Isenberg of Indianapolis was appointed to a three-year term on the infectious disease committee of the American Academy of Otolaryngology-Head and Neck Surgery.

Dr. Hill Hastings II of the Indiana Hand Center in Indianapolis was named the foreign

affairs liaison for the American Society for Surgery of the Hand. At the society's annual meeting, he presided as a faculty member for the course on "Intra-articular Fractures and Fracture Dislocations of the Proximal Interphalangeal Joint" and a skills lab on "Hand Fracture Fixation Strategies." He spoke on "Rotatory Instability of the Elbow: The Lateral Stabilizers" during the annual meeting of the American Shoulder and Elbow Surgeons in Williamsburg, Va. He was a guest lecturer at Oscar Miller Day: A Symposium on Trauma of the

Upper Extremity in Charlotte, N.C.; he spoke on "Operative Management of Complex Articular Fractures of the Distal Radius" and "The Role of the Internal Fixation in Combined Injuries of the Hand."

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, was appointed chairman of the graduate fellows committee at the fall meeting of the American Academy of Facial Plastic and Reconstructive Surgery in Minneapolis.

Dr. Elizabeth S. Peterson, medical director of MetroHealth in Indianapolis, was the planning

committee program co-chair and was a presenter for a conference on "Managed Care for the Primary Care Physician: Balancing Quality and Cost." The conference, held in Indianapolis, was a joint effort of MH Healthcare and Methodist Hospital of Indiana.

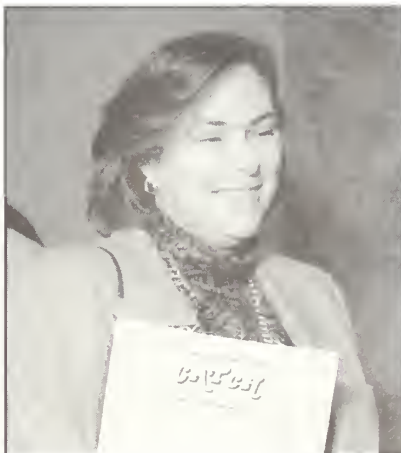
Dr. Richard T. Miyamoto, chairman of the Department of Otolaryngology-Head and Neck Surgery at the Indiana University Medical Center, was an invited speaker at the First European Symposium on Cochlear Implants in Children, held in Nottingham, England, and was inducted into

Bloomington pediatrician receives grant

Carol Touloukian, M.D., a Bloomington pediatrician, was awarded a Community Access to Child Health (CATCH) Planning Grant from the American Academy of Pediatrics. She is one of only seven physicians nationwide to receive such a grant.

She plans to use the grant to conduct a survey of students, parents, school administrators and medical providers about the problems adolescents face at school and in their private lives. The results will indicate how school-linked health care services should be expanded in the middle and high schools in Monroe County.

Dr. Touloukian expects the survey to reveal specifically what problems students are having and what services they lack. For example, there may be a need for support groups or stop-smoking services within



Dr. Touloukian

the school setting, she said.

Expansion of services would likely include additional psychiatric nurses or social workers to counsel students with mental health problems, additional school nurses to treat minor illnesses and sports injuries, administer immu-

nizations and provide other preventive care and development of a network of health care providers in the community to take referrals made by the school nurses and social workers. Dr. Touloukian hopes that by offering services within the schools, students at risk for alcohol abuse, smoking or issues related to sexual behavior will be more readily identified and treated.

Edward Rushton, M.D., director of the CATCH program, said Dr. Touloukian is an outstanding pediatrician who has a unique understanding of adolescents and their problems. He said her ideas for expansion of the school-linked health services "added focus to what Bloomington schools are already doing to help adolescents in their community."

Wyeth-Ayerst Laboratories funded the grant. □

■ people

the Royal Society of Medicine.

Dr. Rank O. Dawson Jr. opened an office in Cincinnati for the practice of plastic, reconstructive and hand surgery and microsurgery.

Activities of Indiana Heart Physicians in Indianapolis include the following: **Dr. H.O. Hickman Jr.** has been cited by the American College of Cardiology for his efforts in developing a revised policy concerning the performance of percutaneous transluminal coronary angioplasty. **Dr. Thomas Hughes** will staff the recently opened office of Indiana Heart Physicians at Kendrick Healthcare in Mooresville. **Dr. J.D. Graham III** presented a session on cardiac risk factors and assessment at a wellness program for faculty and staff of the Washington Township schools.

Dr. Claire A. Horn was appointed medical director of the rheumatology division of the Rehabilitation Hospital of Indiana in Indianapolis.

Dr. George W. Merkle, a Bluffton family and occupational health physician, received his master's degree in public health at the Loma Linda University School of Public Health in Loma Linda, Calif.

Dr. Andrew J. Vicar of Orthopaedics Indianapolis spoke on computer-related diseases of the upper extremities at the national convention of the American Association of Medical Assistants in Indianapolis. He gave a presentation on the treatment of difficult fractures of the distal radius at the trauma conference at Butterworth Hospital in Grand Rapids, Mich.

Dr. Robert M. Seibel of Nashville received a Tony and Mary Hulman Health Achieve-

ment Award in Preventive Medicine and Public Health from the Indiana Public Health Foundation. The award is given for distinguished and outstanding service. Dr. Seibel helped secure increases in community public health program funding for the citizens of Brown County.

Dr. Patrick W. Russell, an Elkhart neurologist, was named to the Indiana Medical Licensing Board.

Dr. Robert L. Meissel, a Terre Haute family physician, received the Weinbaum Award from Union Hospital in Terre Haute. The award honors someone who demonstrates the dedication to quality and innovation in the practice of medicine exemplified by Dr. Jack Weinbaum, who died in 1988.

Dr. Elaine P. Habig, a Lebanon internist, is participating in a clinical trial known as Coumadin Aspirin Reinfarction Study (CARS). The study will enroll 6,000 patients in the United States and Canada.

Dr. John C. Peterson, a Muncie family physician, was appointed to the Delaware County Health Board.

Dr. Timothy J. Story, an Indianapolis internist, was named medical volunteer of the year by the Indiana affiliate of the American Heart Association.

Dr. Dennis E. Stone, a Columbus internist, was elected to fellowship in the American College of Physicians.

Dr. Frederick R. Ridge of Linton was installed as president of the Indiana Academy of Family Physicians.

Dr. Donald L. Martin of Salem has published his second book, titled *Tidbits for Young Doctors and Their Patients (Journal of a County Doctor, Part II)*.

Dr. John R. Dehner of Richmond was named a fellow of the American College of Radiology.

Dr. David C. Brandes, a urological surgeon, was named president of the medical staff of Marion General Hospital. Other officers are **Dr. Regino B. Urgena**, vice president, and **Dr. James C. Camarata**, secretary.

Dr. Maurice E. John of Jeffersonville was inducted as the fourth lifetime honorary member of the Southern African Society for Cataract and Refractive Surgery during a recent visit to South Africa. He delivered the Epstein lecture honoring Dr. Edward Epstein, a pioneer in cataract and lens implantation surgery.

New ISMA members

Bruce J. Ballon, M.D., Lafayette, ophthalmology.

Jack D. Bland, M.D., Newburgh, emergency medicine.

Frank H. Bonser, M.D., Dunkirk, family practice.

Maryann L. Bridge, M.D., Columbus, anatomic/clinical pathology.

Christopher R. Brown, M.D., South Bend, family practice.

Louis B. Cantor, M.D., Indianapolis, ophthalmology.

Jodi S. Carbone, M.D., Granger, obstetrics and gynecology.

Marvin B. Charles, M.D., Crown Point, general surgery.

G. Mitch Cornett, M.D., Franklin, internal medicine.

Kathryn M. Cox Cohoon, M.D., South Bend, family practice.

Daryl F. Daugherty, M.D., Indianapolis, gastroenterology.

John L. Denton, M.D., Anderson, obstetrics and gynecology.

Mukesh I. Desai, M.D., Lafayette, psychiatry.

Antoine K. El-Chami, M.D.,

Mishawaka, anesthesiology.

Rita A. Fleming, M.D.,

Jeffersonville, obstetrics.

Rex A. Flenar, M.D.,

Kendallville, family practice.

Mitchell R. Goldstein, M.D.,

South Bend, psychiatry.

Douglas E. Groswald, M.D.,

Indianapolis, anesthesiology.

Juan Julio Hernandez-Pombo, M.D., Paoli, general surgery.

Karen A. Hoagberg, M.D.,

West Lafayette, psychiatry.

Theresa K. Hoffmann, D.O.,

Fort Wayne, family practice.

Lisa M. Holtsclaw, D.O., Fort

Wayne, family practice.

Jerry L. Jamison, M.D.,

Clarksville, internal medicine.

Henry M. Jones, M.D., Anderson, diagnostic radiology.

Charles M. Kendall, M.D.,

Howe, family practice.

Charles E. Kinsella, M.D.,

Anderson, pulmonary diseases.

Barbara A. Koewler, M.D.,

Danville, obstetrics and gynecology.

Regina A. Kreisle, M.D., West

Lafayette, anatomic/clinical pathology.

Lois K. Lambrecht, M.D.,

Bloomington, internal medicine.

David G. Mark, M.D., South

Bend, gastroenterology.

Julie P. Mark, M.D., South

Bend, pediatrics.

Daniel Meng, M.D., South

Bend, cardiovascular diseases.

Alexander D. Mih, M.D.,

Indianapolis, orthopaedic surgery.

Alexander C. Miller, M.D.,

Gary, orthopaedic surgery.

Thomas J. Montgomery,

M.D., Indianapolis, orthopaedic surgery.

Candace R. Murbach, D.O.,

Leo, family practice.

Michael L. Olinger, M.D.,

Indianapolis, emergency medicine.

Terri Pellow, M.D., South

Bend, psychiatry.

Douglas L. Phillips, D.O.,

Fort Wayne, family practice.

Rhonda L. Phillips, D.O., Fort

Wayne, family practice.

Michael B. Pritz, M.D., India-

napolis, neurological surgery.

Louis M. Profeta, M.D.,

Bloomington, emergency medicine.

James B. Rickert, M.D.,

Bloomington, orthopaedic surgery.

Chester L. Rogers, M.D.,

South Bend, family practice.

Charles E. Sanders Jr., M.D.,

Muncie, rheumatology.

Denise M. Smith, D.O., Fort

Wayne, family practice.

Scott B. Taylor, M.D., Muncie, physical medicine and rehabilitation.

Rhonda S. Trippell, M.D.,

Bloomington, obstetrics and gynecology.

James E. Wallis, M.D.,

Bloomington, general practice.

Erich J. Weidenbener, M.D.,

Bloomington, internal medicine.

Donald R. Westerhausen Jr.,

M.D., South Bend, cardiovascular diseases.

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Advertising index

Arnett Clinic	33
Auto Purchasing Unlimited	95
Central Pharmaceuticals	17
CompHealth	104
Fifth Third Bank	3
Franciscan Placement Service	104
ISMA Insurance Agency	46, Covers
Indiana University Medical Center	5
James Cancer Hospital	10, 11
Medical Protective	93
Palisades Pharmaceuticals	2
Physician Services of America	22
Physician Sourcing & Search	104
Physicians' Directory	74
Physicians Insurance Co. of Indiana	Cover
Practice Management for Professionals	45
Rehabilitation Hospital of Indiana	25
Shore, M.E., CPA	9
21st Century Software	7
University Place	65
U.S. Army	95
Whipple & Co.	23

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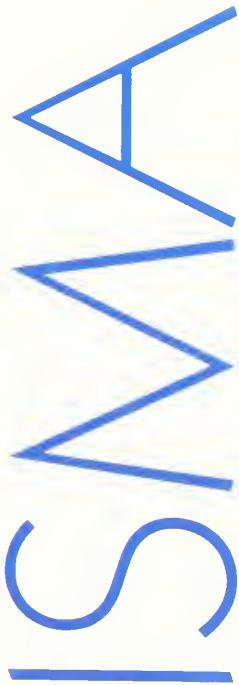


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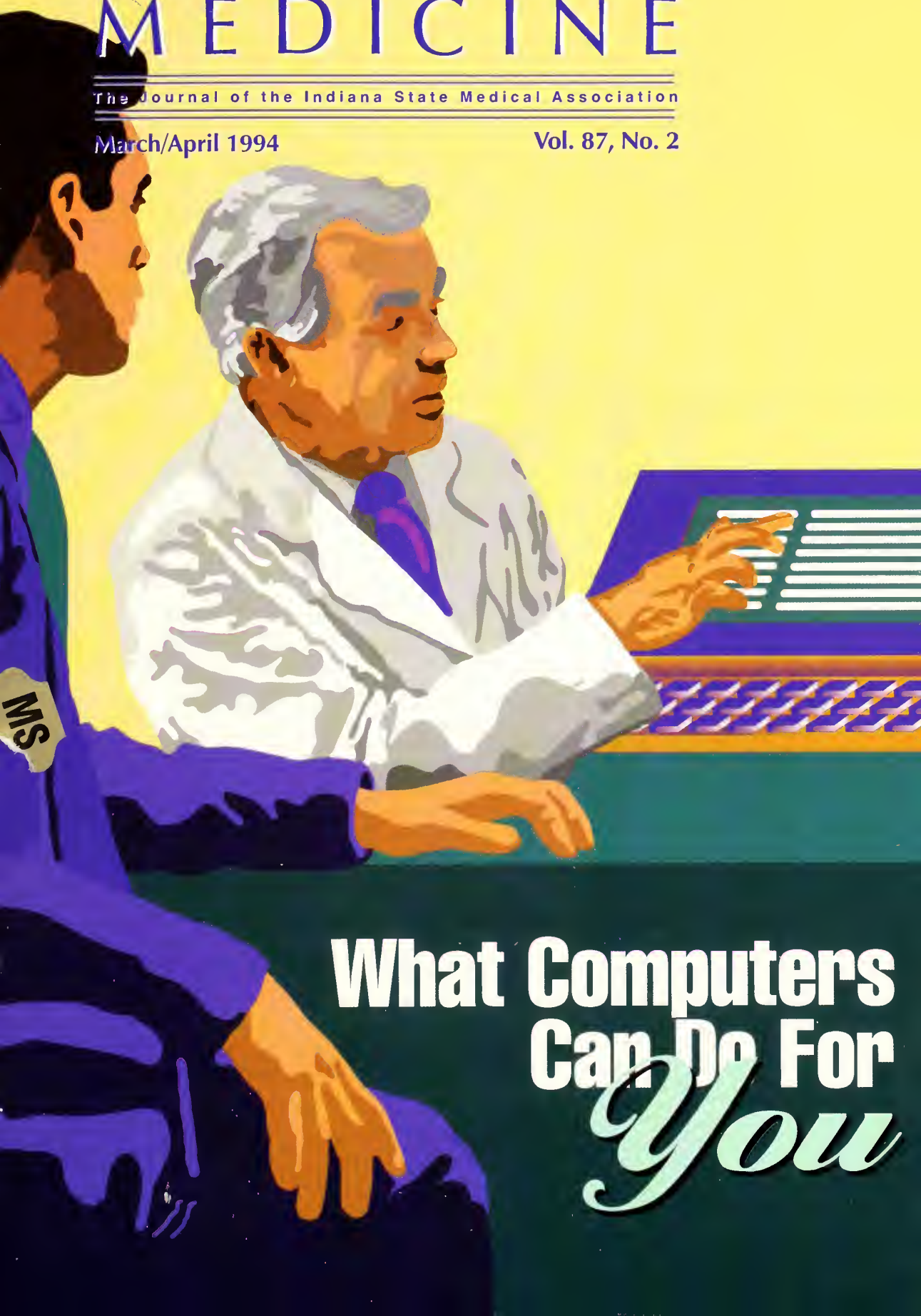
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The Journal of the Indiana State Medical Association

March/April 1994

Vol. 87, No. 2



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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

March/April 1994

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features

Will there be a doctor in the House? 116
INDIANA MEDICINE interviews Timothy Brown, M.D., a Crawfordsville family physician, about issues regarding his run on the Republican ticket for District 41 of the Indiana House of Representatives.

What computers can do for you 122
Several Indiana physicians wonder how they ever got along without their computers. They'll explain how you too can benefit from a computerized practice.

The AMA perspective on antitrust reform 130
The American Medical Association believes antitrust reforms should level the playing field to allow physicians to compete with insurers and other large institutions, thereby benefiting their patients.

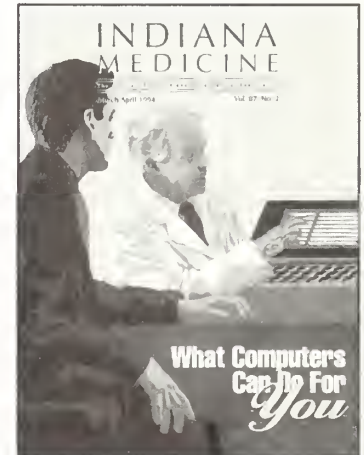
Public opinion on tobacco use, its taxes and public policy 134
Public opinion in Indiana strongly favors legislation that would fund smoking educational programs targeting young people.

Four steps for qualified plan distributions 140
Administrators of qualified plans must follow requirements before making distributions.

Physician stitches award-winning quilts 142
An Indiana pathologist blocks out time in her life to create quilts for friends and relatives.

scientific contribution

**Surgical management of atrial fibrillation:
The maze procedure** 144



Cover story begins on page 122. Cover by Greg Albright, a freelance computer designer in Indianapolis, using Adobe Photoshop and Aldus Free-hand.

departments

stethoscope 108
commentary 110, 112
scientific editorial 114
alliance report 161
from the museum 162
cme calendar 164
news briefs 166
isma leadership 170
obituaries 172
people 174
classifieds 178

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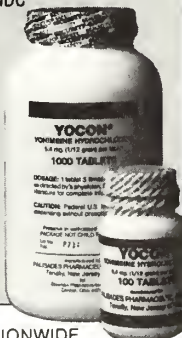
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Indiana court decision could increase malpractice awards

The Indiana Court of Appeals, in a 2-1 decision, adopted a "loss of chance" doctrine that enables more people to recover monetary damages for medical malpractice. Under the ruling, people can recover damages if they show it is more likely than not that a doctor's negligence deprived a patient of a "substantial" chance of survival or a better recovery.

The ISMA objects to the doctrine because it allows people to unfairly recover damages when it is not proven that the doctor's care was the likely cause of the patient's death. The ruling may be appealed to the Indiana Supreme Court.

Physicians urged to campaign for antitrust legislation

ISMA members are encouraged to join the grassroots campaign to ensure that antitrust relief is included in any health system reform legislation. In a campaign to help ensure that physicians and their patients – not insurance companies and actuaries – control patient care in any reformed health care delivery system, physicians are asked to contact their U.S. senators and representatives and urge them to cosponsor the Health Care Antitrust Improvements Act of 1993, introduced as S. 1658 by Sen. Orrin Hatch (R-Utah) and H.R. 3486 by Rep. Bill Archer (R-Texas).

The Hatch-Archer bills would exempt certain collective activities from the antitrust laws if the conduct falls within one of seven safe harbors defined in the legislation, within any additional safe harbors designated by the attorney general or within the terms of a "certificate of review" issued by the attorney general.

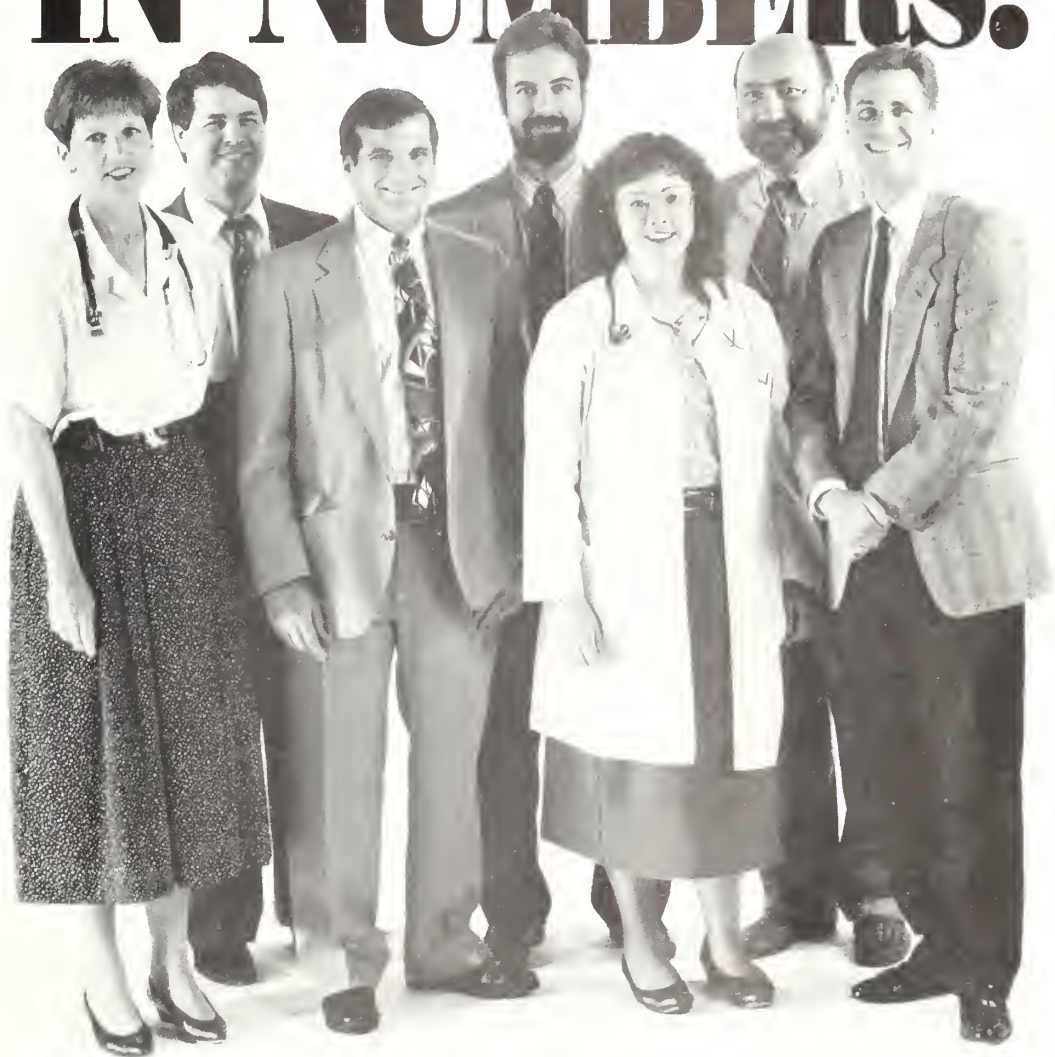
To contact your senator or representative on this issue, call (202) 224-3121 and ask for Sen. Richard Lugar, Sen. Dan Coats or your representative by name. If you do not know your representative or would like the addresses of your senators or representatives, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762.

ISMA outlines key discussion points on health system reform

The ISMA is encouraging its members to emphasize certain key points when speaking to audiences or talking with patients about health system reform. The ISMA priorities on the issue include the following:

- Universal health care coverage for every American, regardless of employment or economic status.
- Assuring that physicians – as patient advocates – play a significant role in deciding how health care is delivered and paid for.
- Guarantees that all patients have a choice of health plans and physicians.
- Relief from antitrust laws that prohibit physicians from negotiating quality of care and conditions of patient coverage with insurance and hospital plans.
- Insurance reforms. □

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Physician knows she chose the right profession

Martha Mechei, M.D.
Crown Point

January 1, 1984 – It is early evening on New Year's Day. I've just awakened, having come home this afternoon from call. I can hear my neighbors in their apartment cells, the train outside, my breathing. Grateful for this chance to be alone, I begin taking down the Christmas cards that were hastily taped on my living room door. Rereading the messages, I see that one has noted that the halfway point in my internship was soon approaching and the "light at the end of the tunnel" would soon arrive. The remark causes me to ponder what I have witnessed and experienced during these past six months.

I recognize the terminability of man so distinctly now. Running to codes, assessing the cold and pasty pale and trying to inspire life once more have made me acutely aware of how little time we have. Hearing the sobs of grieving families flood the halls, I attempt to console them, only to learn of their regrets, their failure to express love when it could have been known.

Fatigue is my constant companion. At morning report, sleep deprivation is listed as a cause of seizures. The interns pick up on the remark and instantaneously go into grand mals. There is a moment of precious laughter as all of us recognize our profound desire for rest.

The support felt from staff and fellow residents is so incredibly strong. "Are you too busy? I can help out ..." "Don't worry about it – things get done." "Call me if you need me." "Don't be afraid to ask for help." Surround-

ing oneself with workaholics is not so bad.

My fears of being unable to assess and correctly handle a situation still remain. I am told they will always be there. When I ask for more criticism of my clinical skills, I am told the fine line on deciding what is right is often clouded. How well I know.

There are never-ending questions I ask myself regarding patient management. Did I do the right thing? Maybe several people are no longer living because I was their doctor. Perhaps a memorial should be erected for "those who died to benefit an intern's education."

The phrase "if something can go wrong, it will" takes on new meaning after spending a rotation in intensive care. Doctors with dark shadows, worried faces, hunched backs, stare upon that which should not have happened. I ineffectively attempted to console a gastroenterologist as he lamented his first bowel perforation during colonoscopy in his seven years of practice. Although the patient was taken to surgery within a half-hour of the event, abdominal abscesses occur. The patient does not do well. The family will sue. The residents call it poor protoplasm. The gastroenterologist anguishes. Everyone grieves. Uniformly this profession has a premium on self-condemnation.

My friends ask if I am happy. My mother tells me I look pale. Throughout medical school, I wondered whether I had made the right decision. That's what makes this New Year's Day so special. For knowing full well the sleepless nights, impending lawsuits and uncollected fees still awaiting me, I can on this day still

appreciate the incredible occupation that I have been given. To see a baby being born or turn a blue person pink makes it all worthwhile. That is "the light at the end of the tunnel," for this internship has solidified me to the profession. I have no doubts. This day my heart is at peace with itself.

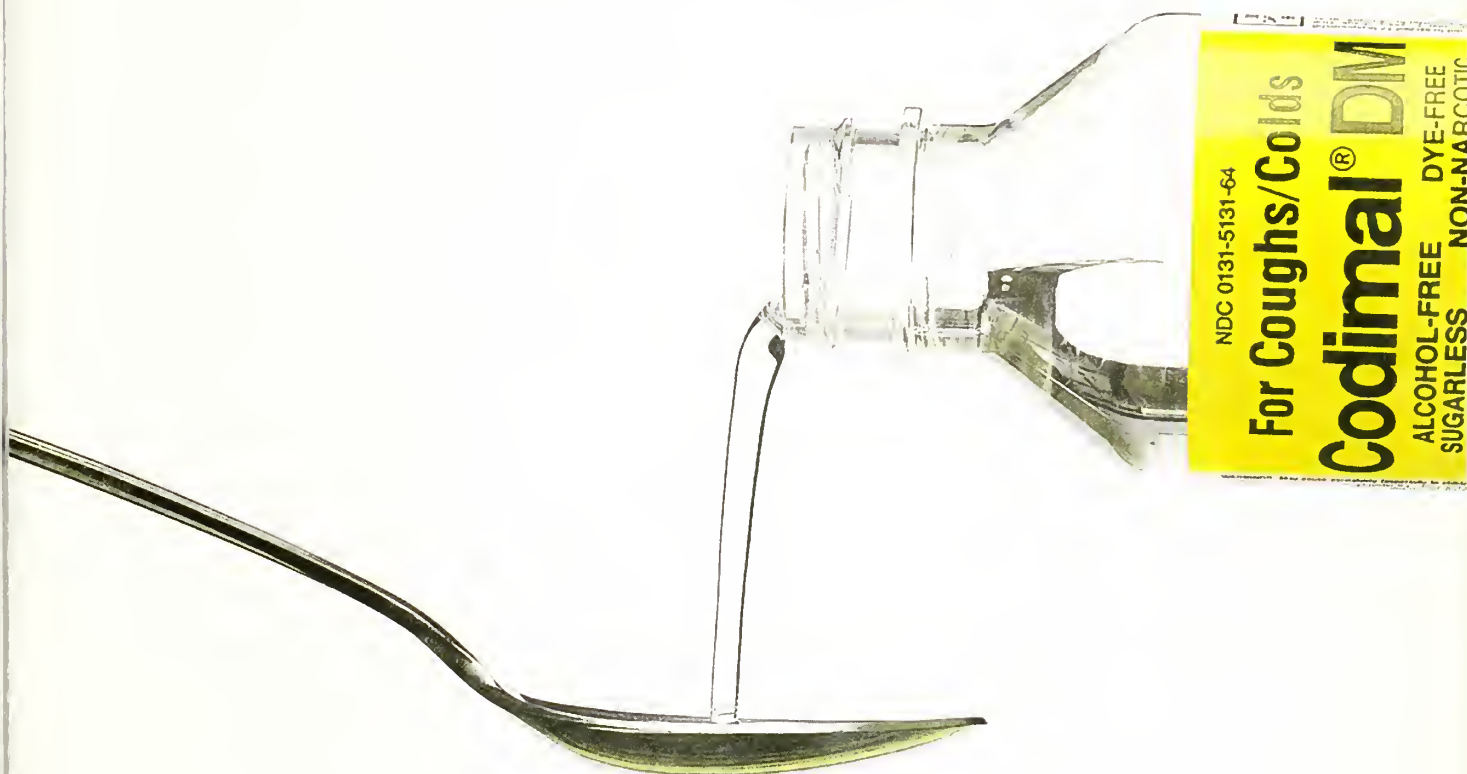
January 1994 – After I wrote the essay on New Year's Day, 1984, I saved it, thinking someday I might want to recall that special moment. I found it the other day and realized that even now I feel so very lucky. It is very easy to become cynical in this profession. Patients lie. I never imagined patients yelling at me. Consultants sometimes are not service-oriented. Insurance companies not only avoid payment, but try hard to break one's spirit en route. Supportive staff sometimes don't help. And yet, when things go well for a patient, the happiness I feel inside is so strong I cannot imagine any other occupation offering that level of satisfaction. As physicians, if we remind ourselves more frequently of our special relationship with the human race, our contributions to history and our passion for knowledge, then no agency will ever be able to alter our internal "hum."

We know we made the right decision. Our hearts are at peace with themselves. ■

Martha Mechei, M.D., wrote the 1984 essay while an intern at Ball Memorial Hospital in Muncie. Since April 1990, she has been director of emergency medicine at St. Anthony Medical Center in Crown Point.

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■ commentary

Blood transfusion at the Indiana University Medical Center

Leo J. McCarthy, M.D.
Clyde G. Culbertson, M.D.

Blood transfusions began at the Indiana University Medical Center soon after 1914 and the arrival of Willis Dew Gatch, M.D., (1877-1962), a 1907 graduate of Johns Hopkins and Dean Charles Emerson's first appointment.

Dr. Gatch was born in Aurora, Ind., and trained under the famous Hopkins surgeon, William S. Halstead, M.D. He was appointed chairman of surgery in 1928 and later became dean of the medical school. He became familiar with the technique of direct transfusions at Hopkins and did many of these in the Long Hospital operating rooms. He invented the adjustable Gatch bed and the Gatch mask for ether anesthesia. He was one of the founding fathers of the American Board of Surgery in 1937. In 1933, he hired Clyde Culbertson, M.D., to establish and direct a centralized clinical pathology laboratory.

As a medical student in 1927, Clyde Culbertson worked at Methodist Hospital and was asked by Horace Banks, M.D., director of pathology, to prepare blood for transfusion to a woman with an ectopic pregnancy. He was given no training on how to do this but used Todd and Stanford's *Clinical Diagnosis*. However, Dr. Gatch, who performed the surgery, did a direct transfusion from a donor to this woman.

Direct transfusions essentially ceased in 1935 when A.C. Kennedy, M.D., a patient of Dr. Gatch with leukemia, required a transfusion. Because Dr. Gatch was too busy to perform the time-consuming direct transfusion, he

asked Dr. Culbertson to give Dr. Kennedy a transfusion of citrated blood. The transfusion was completed uneventfully, but only after considerable difficulty performing an adequate venipuncture because of dull needles. Dr. Gatch had assembled his entire house staff to watch Dr. Culbertson personally give this transfusion. This was the end of the direct transfusion era.

Lyman T. Meiks, M.D., was born in Shelbyville, Ind., received his medical degree from Hopkins in 1927 and was an instructor at Yale from 1928 to 1930. He came to Indiana University in 1931, where he became the first full-time chairman of pediatrics. Dr. Meiks gave transfusions, usually about 250 cc of citrated blood, to selected children in Riley Hospital. The donors were usually par-

ents of the children to be transfused. Therefore, direct transfusions from donor to patient were given here by Dr. Gatch in the late 1920s, and citrated blood was transfused by Dr. Meiks after 1931.

A blood bank was established on campus after 1935 by Dr. Culbertson, making it one of the earliest to be established in this country. Sterile ampules of the anticoagulant sodium citrate were available through Eli Lilly and other pharmaceutical companies. Dr. Culbertson asked Carl Huber, M.D., chairman of the department of obstetrics/gynecology, to ask the husbands of pregnant women to donate blood, thus establishing a blood bank on campus.

One final event firmly established the practice of storing refrigerated citrated blood here and



A direct blood transfusion being performed by Dr. Gatch, Dr. Owen and Ms. Hulto in the Long Hospital operating room in the 1930s.

is vividly recalled in every detail by Dr. Culbertson. Warren Fairbanks, the owner of the *Indianapolis News* and son of Charles Fairbanks, the former vice-president of the United States, developed severe upper gastrointestinal bleeding, and Dr. Gatch removed a large portion of his stomach. To provide blood for Fairbanks, Dr. Gatch sent several *News* employees to the laboratory to give

blood. However, Dr. Culbertson told Dr. Gatch, "If our current blood bank blood isn't good enough for Mr. Fairbanks, it isn't good enough for anyone else either!" Fairbanks was transfused with blood already in the bank. □

This oral history was graciously provided by Dr. Culbertson, director of the clinical laboratories at the Indiana University School of Medicine

from 1933-1946 and current professor emeritus. The Culbertson Professorial Chair for Pathology Education was established in 1988.

Acknowledgment and thanks are given to Nancy Eckerman and Charles Bonsett, M.D., for their assistance in the preparation of this article.

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Editor's note: See related article on page 144.

James C. Dillon, M.D.
Indianapolis

Atrial fibrillation is historically a very old condition, having been referred to at one time as delirium chordis. Atrial fibrillation is a common arrhythmia found in 1% of the population over the age of 60. Determinants of atrial fibrillation are often the size of the left atrium, any underlying organic heart disease and abnormalities in the atrial electrophysiologic function. Atrial fibrillation can be a chronic state or an intermittent or paroxysmal state and can occur in patients who have no evidence of any heart disease. Most, but not all, patients who have sustained atrial fibrillation usually have evidence of pathology.

The cornerstone of the treatment of atrial fibrillation has traditionally been digitalis to control the rate of the ventricular response. Digitalis slows the ventricular rate so congestive heart failure does not occur. Digitalis is not a drug that converts atrial fibrillation to sinus rhythm. In many of the paroxysmal states, conversion to sinus rhythm occurs spontaneously in a matter of hours to a few days. Often this conversion occurs after digitalis has been started, giving the wrong impression that digitalis converted the patient's arrhythmia. Most episodic bouts of atrial fibrillation do not go beyond the second week; if they do, atrial fibrillation may become permanent. More recently, the use of β -blockers in patients without any heart disease or the use of

digitalis and β -blocker or digitalis and calcium blocker to help control rate has increased, although it is questionable whether this usage may not represent lack of judicious use of digitalis as a primary drug treatment.

Traditionally, the drug used to convert patients to sinus rhythm is quinidine. Quinidine was used in the past in doses that were probably toxic or near toxic, and it has fallen out of vogue to use a large amount of this drug. The use of quinidine in small amounts when coupled with electrical cardioversion to sinus rhythm is current practice. The success of conversion back to sinus rhythm is predicated on the length of time the patient has been in atrial fibrillation (the shorter the better). Underlying pathophysiology has a great bearing on long-term success of atrial fibrillation conversion to sinus rhythm.

Keeping patients in sinus rhythm once they convert from atrial fibrillation raises the question of what drug will help keep them in sinus rhythm. Multiple drugs have been evaluated. Digitalis is not a drug that will keep patients in sinus rhythm; quinidine is useful in that regard, and more recently, stalol and amiodarone have been utilized. Despite its toxicity, amiodarone is an effective drug in this regard and is also effective in older patients because of once-a-day administration. Side effects of all these drugs remain a problem.

The risk of embolization occurring with atrial fibrillation is a real and known phenomenon, and non-valvular atrial fibrillation is the most common cardiac disease associated with cerebral embolus. Therefore, the use of anticoag-

ulation in patients who have chronic atrial fibrillation is strongly recommended. Warfarin derivatives are effective in reducing the incidence of embolization, although they do not eliminate the incidence of embolic disease. Attempts to use aspirin and other anti-platelet agents are not as effective, although they have much fewer bleeding side effects than do the warfarin derivatives.

Recently, some patients with uncontrollable atrial fibrillation have been treated with ablation of the AV node. This is successful in stopping conduction to the ventricles but by virtue of producing AV block leads to a permanent pacemaker (VVIR) being used.

In some patients with atrial fibrillation as an end result of sick sinus syndrome, no medicines are needed to control their rate, i.e. ventricular response. Actually, the administration of digitalis and similar pharmaceutical agents to these patients may be harmful. These patients also may require pacemaker therapy to increase their ventricular rates.

This issue of *INDIANA MEDICINE* includes a report of a surgical procedure called the maze procedure for the management of atrial fibrillation. This is a new technique and advocated by small surgical experience. In this procedure, the atrium is resected into small pieces and sewn back together, much like a patchwork quilt. The atrial fibrillation appears to not be able to promulgate itself throughout the maze. This procedure may have some benefits in selected patients, but does involve a major piece of thoracic surgery with many long-term implications that are not well understood. One important question that has not been fully answered

is what happens to the atrial function and transport in patients with maze procedures. One remains skeptical that an atrium will ever retain any kind of atrial transport function after being cut into small pieces. The patient may stay in sinus rhythm on the EKG but may have all the bad effects associated with atrial fibrillation, such as inadequate ventricular booster pump filling, stasis of blood leading to increased thrombosis and decreased cardiac output.

We are in a day and age of decreasing magnitude of gross surgical intervention and less invasive surgery. I wonder whether a major thoracic surgical procedure that cuts the atrium into small pieces is not without risk and may be overkill compared to a little digitalis or newer ablation techniques.

Only time will tell whether the maze operation for atrial fibrillation is an appropriate treatment and whether the questions

raised about its effect on atrial transport and its pathophysiology will be answered. In the meantime, I would caution physicians to remember that the treatment of atrial fibrillation is well established and in most cases is very effective. □

Correspondence: James C. Dillon, M.D., Indiana University, Department of Medicine, University Hospital, Room 3445, 550 N. University Blvd., Indianapolis, IN 46202.

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Will there be a

Bob Carlson
Indianapolis

Timothy Brown, M.D., is one of two declared candidates on the Republican ticket for District 41 of the Indiana House of Representatives. If he wins the May 3 primary election, he'll face an as-yet undeclared Democratic party candidate in November.

A self-described fiscally responsible conservative, Dr. Brown says that pretty much describes the voters in District 41 too. He is a founding partner in Crawfordsville Family Care, where he has practiced medicine since 1985. He is a volunteer physician at the Well Baby Clinic and coordinator of the child protection team of the Department of Public Welfare in Crawfordsville and serves on the board of directors of the Western Indiana Business and Health Alliance.

He earned his medical degree at the University of Illinois College of Medicine in Chicago and completed his residency at Methodist Hospital in Indianapolis before going into private practice.

Dr. Brown is treasurer of the Indiana State Medical Association and has been involved in the state's Medicaid and Medicare reform of physician practice and medical policy issues. He says his work as the ISMA representative to the legislature's Medicaid advisory committee convinced him of the need for physician participation in the legislative process.

In this conversation with INDIANA MEDICINE, Dr. Brown outlines the issues as he sees them, explains how he plans to practice medicine while campaigning and shares his views on job creation, property tax reform and the health care system.

INDIANA MEDICINE: Why did you decide to run for the state legislature?

Brown: Health care sparked my interest in this race. I did a lot of testifying in 1993 at the Statehouse about Medicaid and Medicaid reform issues for the state medical association and found that there were a great need and a great desire for information on health care. Knowing that the federal government was going to pass legislation mandating states to have a plan in 1995, I felt that there would be a great need for a physician and patient advocate in the Statehouse in 1995. They say everything in politics is timing. The seat was open and I took the opportunity.

INDIANA MEDICINE: The seat was open?

Brown: Yes. Rep. Dan Pool is giving up the seat to run against John Myers for the U.S. House of Representatives in District 7. So that makes the Republican primary an open one. As of this day, the thirty-first of January, there are only two declared candidates, myself and Greg Miller, a Crawfordsville attorney. There is a lot of talk that another person will get in the race, probably from southern Tippecanoe County, and I fully expect that there will be three candidates in the Republican primary on May 3.

INDIANA MEDICINE: What issues will you bring to the campaign?

Brown: I think security as a global issue is important to people of this district. Financial security, that they don't lose their job or



doctor in the House?

get down-scaled in a job. Security from crime. Even though Montgomery County doesn't have a high incidence of crime, there have been a couple cases of violent crime, so people are very wary of that. And health care security, so people don't lose their health care or go into financial ruin because of health care.

INDIANA MEDICINE: *These sound like mainstream issues.*

Brown: Correct. I'm a small businessman. My associates and I own this business. We have to deal with state government, so we understand the hassles of regulation and rules. And small business accounts for 90% of the new jobs in our state. There are a lot of jobs out there. We just need to not strangle them with government over-regulation.

I am also a parent. I have four children, so the education issues impact me very monumentally. Over 50% of the state budget is in educational issues. I feel that I have something to offer there as far as children going through the educational process.

As a physician, I think I have some expertise and some information that I can help lend to the health care debate. So I see myself uniquely qualified as a small businessman, as a parent and as a physician.

INDIANA MEDICINE: *What elements of health care reform will you be most concerned about?*

Brown: I am concerned about regulation and restriction. Most of the plans that I have seen have some central control, both federal and state. I think that's going to

lessen the quality of care at the patient-doctor level. I would like to see freedom of choices remain an option. If a patient comes to you and together you decide on a certain treatment that may not be the norm as determined by the central board, under some systems you will be restricted, you will be unable to get that treatment. You will be unable to contract outside of what the central authority says you can do. I think that will do a great disservice to patients. I would like to see the freedoms continue, or at least the opportunity to continue communication and dialogue about options.

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So I see myself uniquely qualified as a small businessman, as a parent and as a physician.
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INDIANA MEDICINE: *What other issues are you especially interested in and what is your position on those issues?*

Brown: I think one of the other issues is property tax reform in the state of Indiana and specifically in Montgomery County, school funding via property tax and its growth. How much should schools be funded by the property tax route? I don't have the answer. Should we have a fixed percent? Should there be a cap? I don't like caps on anything, but I think we need to look

at alternative funding mechanisms for schools. Jobs and security issues, property tax and crime, I think, are probably the three big issues that this electorate's looking at.

INDIANA MEDICINE: *How do you plan to juggle the demands of campaigning and running your part of the practice?*

Brown: I'm in a group which, thankfully, right now supports my efforts to campaign, so there is somebody in a call coverage situation. I have basically scheduled time so that I can have meetings and do different activities with different organizations. It's already in the schedule. I anticipate just through the primary that I could have a 20% drop in income this year, due to this campaign. I'm budgeting my personal finances with that expectation. I have also hired someone part-time to help with media, to help with some of the issues that are hard for me to attend to, scheduling, making sure things get printed on time and things like that.

INDIANA MEDICINE: *If you are elected, how do you see this affecting your practice?*

Brown: Most significantly, I will give up obstetrics. Right now, as a family practitioner, I'm doing about 60 deliveries a year. I will be more of a part-time practitioner, probably two-thirds of the time I practice medicine now. We're getting a new associate in September of this year, so if I'm successful, that will help ease some of the burden within the group.

INDIANA MEDICINE: **What do your patients think about your decision to run for office?**

Brown: The vast majority have been very supportive, very positive and upbeat. They're excited for me and would like to see me there and understand my desires to do it.

INDIANA MEDICINE: **Have you sought advice from any other physicians who have run for office?**

Brown: Yes. I talked to one in our community, Dr. Marion Kirtley. He was a state senator from '62 to '66. That was back when the assembly only met every other year. He continued to have a full-time practice. I have met with Dr. Ned Lamkin, who has been the last physician in the legislature, in the late '70s, early '80s. He's an endocrinologist in Indianapolis.

INDIANA MEDICINE: **No other physicians in the legislature?**

Brown: No other physicians at this time, no other physician candidates at this time. Twenty-six

attorneys, two law students. And I'm running against an attorney. I've also talked to [Dr.] John Knote of Lafayette who made a run for state senator and said it was very exciting, a lot of hard

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Well, in this country, you can walk across the threshold of any emergency room door. Nobody stops you from doing that. And they have to triage you, they have to make an assessment of your health. So I don't necessarily buy the idea that people can't go somewhere.”

work, but you meet a lot of people that you would never meet being a physician. It's really kind of exciting that way.

INDIANA MEDICINE: **What kind of advice have they given you?**

Brown: Their experience was don't be a one-issue candidate with health care. That's what we're trying to avoid by focusing on my experience in small business, as a parent and then as a physician patient advocate.

Some of the local leaders have given me a wide variety of advice. Name recognition is number one.

Any way to get your name out there. Personal appearances, shaking hands and going door-to-door. Our county Republican chairman says Crawfordsville's the yard sign capital of Indiana, so that will be a part of campaigning.

INDIANA MEDICINE: **Have you got one yet?**

Brown: We have a logo in development. The signs will be hitting the trail in April.

INDIANA MEDICINE: **Some people, including Sen. Daniel Moynihan (D-N.Y.), have been saying that maybe we don't have a health care crisis. What do you think?**

Brown: Yes. He's chairman of the Senate Finance Committee, which health care legislation has to go through. I think you need to be very careful what you look at. People say we need universal access or universal coverage. The president's been saying he will not accept a bill unless there's universal coverage. Well, in this country, you can walk across the threshold of any emergency room door. Nobody stops you from doing that. And they have to triage you, they have to make an assessment of your health. So I don't necessarily buy the idea that people can't go somewhere. Yes, there are shortages, but some of those are manpower shortages. There's not enough primary care for inner city or rural areas. There's not enough prenatal care in some areas. Yes, those are issues.

Eighty-five percent of the populace has health insurance. It's estimated that 40% to 60% of



those with insurance will have less coverage or pay more money for the same coverage. I think that's a big issue. When you look at this number of 37 million [uninsured] up to the 58 million that President Clinton threw out [in his State of the Union speech], two-thirds to three-fourths of that number is in a state of flux, meaning they're in and out of insurance. When you really look at who is hard-core uninsured, the number is much lower. One group last year put that number at only nine million. Maybe that is the number the government should be taking care of, and maybe we should look at who we are really trying to cover when we say we want universal coverage.

I think we can say there are a lot of things wrong with the financing of health care, and that creates maybe some decisions that aren't good. But if you look at care, we do have a lot of good technology. People want to come to this country for care when there's a problem. I think the statistics that people use to compare us to other countries are a little bit skewed. I think we rank ninth or 10th in the world in in-

fant mortality. Well, there are a lot of countries that don't even care for the 26-week premature infant. That's considered a still-birth and not an infant mortality.

We don't rank very high in life expectancy. Well, the number one thing that takes away from what we call years of potential life is accidents. And that has nothing to do with how I deliver care in the office. It's the auto accidents, the alcohol related to accidents, boating accidents, gun safety, it's all those issues that drag down the average. Don't condemn the health care system because of that. Those are choice and freedom issues. People have to recognize that there are risks and benefits and there's responsibility [for making those choices]. You can't blame the system because you have accepted a high risk.

I think it's very hard to get into an individual person and say for them what is a better choice. I can't say what is the best choice for any one individual. Hopefully through information, they'll make informed choices.

INDIANA MEDICINE: **Is there any-**



thing else that you'd like to add in regard to your candidacy for the state legislature?

Brown: I think '94-'95 is going to be a time to bring physicians together. [I think there needs to] be a resource person within the General Assembly other legislators can turn to when they don't understand the implications of a complex health care issue. I would like to be that person. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

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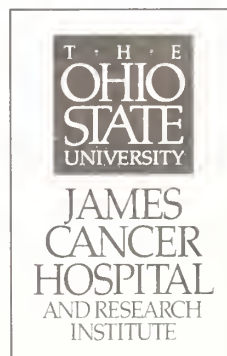


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What computers can do for you

Bob Carlson
Indianapolis

If you think the health care system is changing fast now, you ain't seen nothin' yet. Before you stick more pins in your Bill and Hillary dolls, hold on. The truth is, it probably all would have happened anyway. And one of the biggest reasons is computers.

If you're like most physicians, your practice management functions have probably been automated since sometime in the '80s. Things like billing, accounts receivable, insurance processing and appointment scheduling – front office stuff. That was the '80s. It's 1994, and now it's your turn.

Exam room, late 1994

You greet your patient, close the exam room door and sit down. With a plastic stylus in hand, you touch the screen of your portable laptop computer to instantly display the patient's chart. As you talk with the patient, you complete the medical record for this encounter, again, simply by touching the plastic stylus to the computer screen. Subjective, objective, assessment, plan. You touch the screen, and a laser printer in the corner of the exam room quietly prints out a prescription and four pages of patient educational material. You ask about the family.

The patient's electronic chart now includes all the data you entered moments ago on your laptop. As the patient leaves your office, another laser printer automatically generates a hard copy that will be filed with the old

paper chart in the file room at the end of the day. You touch the screen with the stylus. Two minutes behind schedule, you pick up your laptop and head down the hall to see your next patient.

A laptop in every lap?

This scenario is not science fiction. It's based on cutting edge technology and will be a reality in at least one practice right here in Indiana by the end of the year. If you look past the bells and whistles, it's obviously a great way to save time, improve care, cut down on paperwork and boost efficiency.

Those are also the reasons you invested in a computer system for the front office, remember? Computers revolutionized the business side of practicing medicine, and now almost no physician would be without them.

And that's exactly the point.

Computers are driving change in health care, perhaps more than you-know-who in Washington, D.C. Without computers, there would be no HMOs, no utilization review, no smart cards, no electronic charts and no information highway.

So if you can't see yourself with a laptop in your lap, you may not be practicing medicine in five years.

Superdocs in Evansville

Greg Hindahl, M.D., and Kim Volz, M.D., can't wait for their laptops. "A monitor in every exam room gets expensive. That's why we went to the laptop system. You can just carry it from room to room," explains Dr. Hindahl.

Actually, they already use laptop computers in their Evansville family practice. It's *touch-screen* laptops they're waiting for so they can have both the portability of laptops and the speed of the SuperDOC program they helped develop for family practice use. The SuperDOC program is fast because it allows the physician to touch the screen with a stylus and select words when doing dictation. No transcribing necessary.

"Ideally, you finish the note and it gets printed as the patient is leaving. If they call back an hour later, you've already got a typed note. For acute illnesses in family practice, especially if you're seeing a lot of sick kids, it's nice to have immediate access to those notes when you get a call at night," says Dr. Volz. Immediate access? With portable laptops, of course, which go wherever Drs. Hindahl and Volz go.

For Dr. Hindahl, the biggest advantage of using laptops comes into play in a group practice situation. "When you're on call for the other person, unless you want to go to the office every time a patient calls, you don't have a very good idea of that patient's medical problems. With a laptop, you have all the vital information you need to give that patient a good answer while you're talking to them on the phone, no matter where you are."

While waiting for their touch-screen laptops, they still dictate their notes the old-fashioned way, have them transcribed and entered in the office computer network. At the end of the day, it takes about 30 seconds to update

their laptops with that day's notes from the network.

They use another program called SOAP, which they describe as basically an electronic chart to keep track of patient information. It also checks for drug interactions, automatically, and has a "Chart Card" option that allows a patient's records to be transferred onto a plastic credit card device or onto a regular floppy disk. If the patient needs to see another doctor, the patient's entire medical record is instantly available to the new doctor.

Drs. Hindahl and Volz admit to being excited about using computers in their work. Their front office is also computerized, but as Dr. Volz explains, "The front office is really not handled by us. We just know it's there and does its job. As physicians, what we're actually working with is the clinical part."

Try it, you'll like it

There's good reason to concentrate on the clinical side, maintains Ben Park, M.D., a family physician in Lebanon, Ind., and president of Advanced Medical Information Systems in Indianapolis.

"If you have a clerk in the front office that's making \$20,000 a year and you improve that person's productivity by 10%, what's your gain? Now take a physician who's making \$100,000 a year and improve his or her productivity 10%. It's clear where you ought to be spending your money."

As everyone becomes more cost-conscious about health care, he also sees increasing pressure on physicians to be as efficient as possible and to provide more



Kim Volz, M.D., left, and Greg Hindahl, M.D., Evansville family practitioners, are avid computer users and are awaiting the arrival of their touch-screen laptop computers.

information about how they take care of their patients.

Dr. Park, who went to graduate school in computer science after completing medical school, founded Advanced Medical Information Systems in 1986. The firm specializes in turnkey office automation systems for the physician's office. "Our focus is on the medical side," says Dr. Park, "although we do the other things, too. Billing, scheduling and sending electronic claims are kind of a given in today's market."

His advice, from one doctor to another?

"Try it, you'll like it. And your nurse'll love it. And if your nurse is happy, you're happy."

He cautions, though, that a computerized medical records system is entirely different from a practice management system. "A practice manager might make the decision about what kind of billing system to get, but not what kind of medical records system. This is a physician decision. It's highly personal."

Managed care and the highway

In a managed care environment, the primary care physician is the gatekeeper for all health care in the patient's life. Equipped with a computerized clinical information system, the physician is responsible for managing the patient's care, whether that care is provided in the office, by a specialist to whom the patient is referred, at a lab or by a pharmacy. To do that, the physician must be able to access data across the continuum of the patient's care.

Here's another scenario.

A patient visits his doctor on the south side of town, is treated and released. An hour later, he is

involved in a traffic accident on the north side of town. He is rushed to a hospital emergency department, where his number is entered into the computer. His complete medical record appears on the screen, including his physician's office visit notes, and a potentially harmful drug interaction is avoided.

How did the notes about the office visit get from the physician's office to the hospital's emergency department computer? Via the information highway, of course, which links every provider with every other provider.

End of scenario.

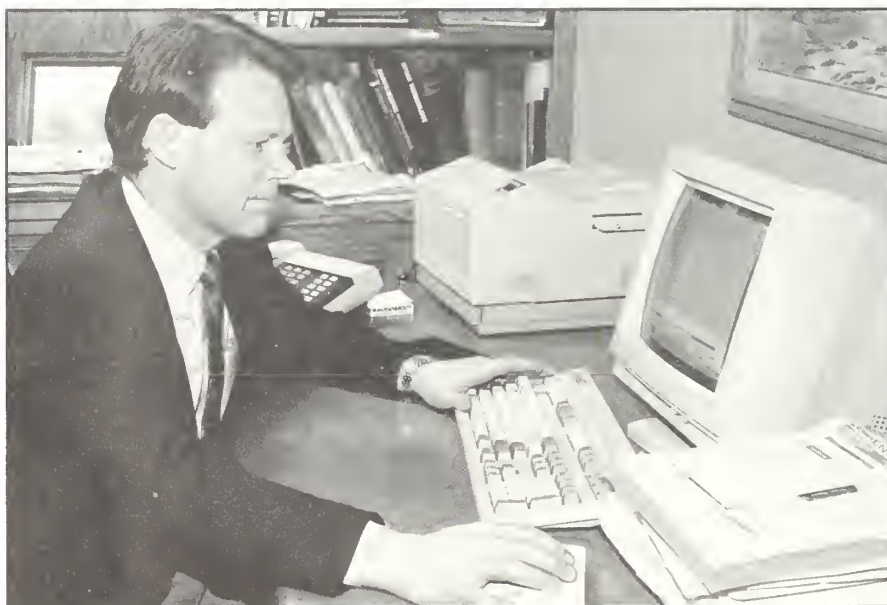
According to Stephen Furry, partner in health care information systems consulting with Ernst & Young in Indianapolis, three new components are necessary to make this scenario possible.

First, a *common patient identifier*.

Furry explains. "When I go to a physician office now, I'm assigned a number. When I go to a hospital, I'm assigned another number. When I go to a lab, I'm assigned another number. When I go to an HMO, I'm assigned another number. If my doctor is going to manage my care across these entities, he or she has got to have a way to identify Steve Furry in the entire process."

Second, a *clinical data repository*. This is the patient's automated medical record, which is made up of information from a number of different care-giving entities, including the physician.

Third, the *information highway*, which electronically links the care-giving entities to each other and to the clinical data repository.



Ben Park, M.D., a Lebanon family practitioner, is the founder of Advanced Medical Information Systems, which specializes in turnkey office automation systems for physicians' offices.

These three components need to be community-wide, says Furry. He compares the entire system to bank automatic teller machine (ATM) networks. "The only difference between an ATM network and a medical network is the amount of data being moved around. When you start moving an x-ray from point A to point B, you're talking about a huge amount of data. As soon as technology catches up, you're going to have clinical networks like you see ATM networks."

How soon will technology catch up?

"We're probably five to 10 years away from nationwide coverage," says Furry. "Before then, you're going to see pockets of local clinical networks."

Michiana Health Information Network

Northern Indiana may be one of the first clinical network pockets in the country. Alan Snell, M.D., admits he's not a technical wizard when it comes to computers. But he has a vision.

"I'm on the medical staff of two hospitals. I am also a customer of the South Bend Medical Foundation, which we use as our lab in my own practice. Then there are the radiology groups associated with each of the hospitals. I can envision our own computer system in the office linked to these other entities so that my staff, my two associate physicians and I can call up data from any of these entities," says Dr. Snell.

About 18 months ago, he assembled the Michiana Health Information Network, a task force representing different health care institutions in the South Bend/Elkhart area, all of whom were

already computerized. Consultants and computer systems vendors, communications companies like Ameritech, and people involved in similar networks elsewhere in the country were invited. Site visits were conducted.

"A lot of it was just fact-finding and getting educated," says Dr. Snell, "trying to decide what obstacles we would have to overcome."

One of the obstacles is a clash of cultures in the health care community – the hospital culture versus the physician culture, for example. There is also an unwillingness to share information, one hospital with another, one physician with another. "There's still some feeling of proprietary information," says Dr. Snell.

As a physician, Snell is enthusiastic about another potential benefit of a health care information network, i.e., using the com-

munity health care database to assess community health status. How much information is going to be needed? Who will have access? Dr. Snell believes the Michiana Health Information Network's common goal of community health and a growing spirit of collaboration will help to find solutions to these and other questions.

"As we are successful in collaborating on information sharing, we can start asking ourselves whether we as a community can share our health care resources in other areas such as facilities, bed space, centers of excellence, transportation systems, instead of duplicating them. It's going to be too difficult, too costly, too time-consuming to try to be everything to everybody. This may be a good way for us to build those trust relationships. The chemistry is right."

ASIM endorses patient records software

The American Society of Internal Medicine (ASIM) recently gave its endorsement to a patient records and office management software package developed by MedicaLogic, Inc., of Beaverton, Ore. The software was designed by internist Mark Leavitt, M.D.

ASIM officials said the software stood out from the more than 300 proposals submitted because it is tailored to the practice needs and work habits of internists. The patient records software, ClinicaLogic, allows physicians to access patient information away from the office. A software option called PharmacoLogic lets physicians find out drug prices and ensure patients get the most effective drugs for their illnesses.

Currently less than 5% of physicians use electronic clinical records. ASIM hopes its endorsement will encourage physicians to move away from paper clinical records and incorporate computers into their day-to-day practices.

For more information on MedicaLogic, call Sue Reber or Mark Leavitt, M.D., (503) 645-6442. □

Alan Snell, M.D., a South Bend family practitioner, envisions the establishment of a medical electronic information highway resulting from the formation of a northern Indiana task force composed of hospitals, physicians and laboratories.



MedNet at Methodist Hospital

About 140 miles south, in Indianapolis, Methodist Hospital is building its own piece of the electronic highway. It's called Indiana MedNet, and if you're on the medical staff at Methodist, or have a close referral relationship, it won't cost you a dime to have your workstation connected to the network.

More than 200 physicians are on Indiana MedNet so far. That's right on target, according to Barbara Stayton, Methodist's director of physician services. The network's first day of operation was Sept. 20, 1993. She projects 300 subscribers by the end of

1994.

Physicians on MedNet are electronically linked to different components of Methodist Hospital, its subsidiaries and off-campus sites. Instead of spending time on the phone or waiting for the mail, subscribing physicians get their reports from the hospital electronically on their office computer. Some access their office computer from home via modem.

Stayton explains that because of the hospital's size and the volume of paperwork that goes to physicians, the flow of paper is sometimes not as timely as physicians would like. "If we can send it electronically, it's better for patient care, and it's certainly easier

for physicians and their office staff."

Indiana MedNet subscribers continue to receive their regular Methodist mail for the first 30 days. Then they're asked if they're ready to have the paper flow turned off. "We want them to have a comfort level before we do that," says Stayton.

Next to go on-line are the hospital's medical records department, transplant services, operating room services, radiation therapy and Indiana Home Health, a subsidiary of Methodist Hospital. Eventually, Indiana MedNet will link physicians, pharmacies, managed care companies and other hospitals throughout the state.

"Traditionally, hospital departments have not interacted one-on-one with physicians. This is a different mind-set. We're not doing this to meet our needs. We're doing this to meet the needs of the physicians," says Stayton.

Caveat emptor

"Some physicians are on their second or third practice management system and are looking for a third or fourth," says John Moeller, account representative with Horine & Associates in Indianapolis. Horine & Associates specializes in physician software.

Moeller suggests that the reasons for replacing systems this frequently point to faulty selection criteria. The computer system is not expandable to keep pace with a growing practice. The system has not performed as promised, or system support may have been inadequate.

Medic Computer Systems in Indianapolis also markets medical data processing systems to physi-

cians. "I think some people look at the initial cost only and ignore the long-term cost. That could mean they have to buy a whole new system if they want to go from two terminals to three terminals," says Gary Havercamp, Medic Computer Systems regional sales manager.

When upgrading an existing system or installing new capabilities, such as a computerized clinical records system, Moeller and Havercamp caution that a variety of factors other than price should be considered. In their promotional literature, medical computer systems vendors often include a chart entitled "Buying Criteria" to illustrate this point.

Criteria used by "First System" buyers, in order of importance, are price, ease of implementation, ease of use, software fit, function, equipment, growth, support, documentation and vendor. In contrast, more enlightened "Second System" buyer criteria are support (56%), vendor, equipment, growth, software fit, documentation, function, ease of implementation, ease of use and price.

"You're buying the business partnership as well as the computer," says Furry.

Furry emphasizes that of the three components in a physician's medical information system, the financial (billing and general accounting), the administrative (scheduling, registration, word processing) and the clinical (from office visit notes to complete patient medical record), the clinical component is the least developed.

"The clinical information products that are out there aren't very mature. But by the same token, there is very, very high value and high benefit associated

with these systems if you put them in right."

Havercamp of Medic Computer Systems illustrates the potential benefits of clinical information systems with an analogy. "It's kind of like buying a car in February. You may not think you need air conditioning, but you're glad you've got it in July."

With new technology such as voice recognition software making headlines, Moeller of Horine & Associates cautions physicians to "make sure you're buying steak and not sizzle. There are a lot of hot articles in all the physician magazines about all this neat, fun stuff. Well, it is neat and fun, but some of it is not really ready for application in a live environment."

How to get there from here

"Several years ago, I was at the American Academy of Family Practice annual meeting and encountered a couple of vendors who had electronic chart programs," recalls Dr. Volz when asked how he and his partner, Dr. Hindahl, became interested in using computers in their clinical work.

Dr. Hindahl says the academy has a session about computers at every annual meeting so people can learn about what's available, what works and what doesn't. "When you work with hardware and software both, it's just a continual weeding out process."

Their advice? "First, decide what you want the system to do. Then you have to look at each software application and see if it does what you want. Definitely try it. Don't commit to buying a program and find out two weeks later that the way it works is totally alien to you and that you

don't like it."

Dr. Park agrees. "Decide if you want to make any changes in the way you practice now, and then look for a system that can accommodate the style of practice you want." He also encourages physicians to attend trade shows like the one sponsored annually by the Society for Computer Applications and Medical Information in Washington, D.C.

Today, the practice management component of Ireland Road Family Physicians in South Bend is automated. Within five years, Dr. Snell thinks the practice may be completely paperless. "Our goal will be to use hand-held, note-pad type computers that you can carry from exam room to exam room or even to the hospital. We also want to get into interactive patient education software."

"Sometimes the easiest way for physicians to get comfortable with technology is to just do the practice management part. See where the efficiencies are, where the problems are and learn how to deal with them. Then they'll be more comfortable with computerized medical records and information sharing," says Dr. Snell.

"If you have someone on staff who is knowledgeable, that's really the best choice," advises Moeller. "If you don't have anybody in-house, get a hired gun. A lot of groups use consultants. Step two, with that resource, develop your true needs. Really figure out what you want before you go out into the marketplace and get barraged by all the different products. A lot of groups start with vendor demonstrations before they know what they want. They buy it, and it doesn't meet their needs because they really

didn't develop their needs.

"Another tremendous resource for physicians is the hospital. Go to the physician relations person and say, 'I'm looking for a system. Do you have anybody who can help me with that?'"

Havercamp recommends three steps. "First, see a demonstration by the vendor to get an idea of the capabilities of that system. Second, go on a site visit to see the system in action at a real practice. You might want to make two or three of those visits, with or without the salesperson. Third, maybe a more detailed demonstration with the vendor's trainer along to answer the doctor's and staff's detailed questions."

Furry says medical societies and physician associations are putting on more trade shows, "but you'll be faced with salesmen

trying to sell you a system. Unfortunately, those shows don't do a good job of training a physician what to look for, what differentiates a system, what makes a good system, what makes a bad system."

To analyze needs, to find out what's in the marketplace, to answer questions about system implementation, training, support, maintenance, enhancement and expandability, physicians need a professional, says Furry. Not surprisingly, he recommends himself. "I'm an adviser. I don't sell it."

"I would also turn to medical schools, because they don't sell it, either. Their business is research, data collection, clinical profiling. They're in the medical information business, so they've had an opportunity to try these systems. Doctors can talk to their peers.

It's a very clinically oriented environment. Dr. Clem McDonald at Regenstrief has been collecting patient data for 10 years on a system that he developed." (Dr. McDonald is co-director of Regenstrief Institute for Health Care at the Indiana University Medical Center in Indianapolis.)

Finally, there's the free, no-obligation initial consultation. "Sometimes what physicians are looking for is something we can provide over breakfast or lunch. Often that's all they really need. Hopefully we can share enough of our experience that they'll have a better understanding of what's involved." □

The author is a health care communications consultant in Indianapolis.

Sources for more information

For more information on the products or services mentioned in the accompanying story on computers in medical practices, the following people may be contacted:

Stephen L. Furry
Ernst & Young
Indianapolis
(317) 681-7000

Gary Havercamp
Medic Computer Systems
Indianapolis
(317) 465-9294
1-800-334-8534

Greg Hindahl, M.D.
Mount Pleasant Family Practice
Evansville
(812) 867-8000

Clement McDonald, M.D.
Regenstrief Institute for Health Care
Indianapolis
(317) 630-7070

John Moeller
Horine & Associates
Indianapolis
(317) 684-2160

Ben Park, M.D.
Advanced Medical Info. Systems
Indianapolis
(317) 875-8577

Jean Shoemaker
SuperDOC! Medical Info. Systems
Harrisonburg, Va.
1-800-541-0322

Alan Snell, M.D.
Michiana Health Info. Network
South Bend
(219) 236-7741

Barbara Stayton
Methodist Hospital
Indianapolis
(317) 929-2650

Kelly Terry
Patient Medical Records, Inc.
Brownfield, Texas
1-800-285-7627

Kim Volz, M.D.
Mount Pleasant Family Practice
Evansville
(812) 867-8000

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Joy L. Fridley, MD. – Associate Medical Director
Blood Bank of San Bernardino and Riverside Counties
- **Transfusion Options other than Volunteer Blood**
Linda Chambers, MD – Medical Director Transfusion Service
Childrens Hospital, Columbus, OH
- **When to Prescribe Blood – Determining the Transfusion Trigger**
Merlin Sayers, MD – Director, Transfusion Surveillance,
Puget Sound Blood Center
- **Identification and Management of Transfusion Reactions**
Jay Menitove, MD – Deputy Director, Medical Services
Hoxworth Blood Center, Univ. of Cincinnati Medical Center
- **Making Sense of Blood Donor Infectious Disease Testing**
Robert G. Hoff, MD – Associate Medical Director
American Red Cross Blood Services Northeast Region

The AMA perspective on antitrust reform

Antitrust reforms are necessary to facilitate the formation of physician joint venture networks that will contract with health plans, or that will evolve into health plans by assuming the insurance function as well as the health care delivery function. While it is not impossible for physician joint venture networks to be created under the current antitrust laws, it is much easier for an insurance company, a hospital or another institution to organize a network of physicians in compliance with the antitrust laws than it is for physicians. Antitrust reforms should level the playing field in order to allow physicians to compete with insurers and other large institutions. These reforms will benefit the public by increasing competition, by allowing the professionals most knowledgeable about patient care to direct health care networks and health plans and by forming health plans with the patients' interests in mind. Specific antitrust reforms are necessary to facilitate physician joint venture networks.

Safety zones

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have issued enforcement policies that create an antitrust "safety zone." Physician network joint ventures that fall within this safety zone are deemed to be legal organizations under the antitrust laws and not illegal conspiracies. The AMA agrees with the concept of creating antitrust safety zones for the formation of physician network

joint ventures, but believes that the DOJ/FTC safety zone is much too restrictive. The AMA believes that any safety zone should have the following characteristics:

- **Size** – The DOJ/FTC safety zone is limited to 20% of physicians in a market, in aggregate and by specialty. One of any specialist is allowed if there are so few as to make it impossible to comply with the 20% limit. The AMA believes this size limit is unrealistically small, especially for PPO-type networks. The safety zone should be 50% of physicians in aggregate and by specialty for "nonexclusive" networks, according to the AMA. Nonexclusive networks are those that allow physician members to join other networks. The AMA's position is that exclusive networks, those that do not allow physician members to join competing networks, should include 35% of physicians in aggregate and by specialty. The sources for these proposed limits are previous DOJ/FTC policy. In addition, the AMA suggests that a network should be allowed to have two of any specialist on a nonexclusive basis when it is impossible to comply with size limits. Two are necessary to allow one physician to cover for the other.

- **Measurement of size** – The DOJ/FTC measures the size of a network by calculating the number of physicians in the network as a percent of the total number of physicians in the market at issue. The AMA believes that such a measurement is not a reflection of the true competitive significance of a network, especially for nonexclusive networks. For ex-

ample, a network could be formed that exceeds the safety zone limit, yet has no market share. Further, a network could be formed that exceeds the safety zone limit but has little competitive significance because numerous other competing physician networks are in the market. The AMA believes the competitive significance of a network can be better measured by calculating the number of physicians in a network as a percent of all physician positions in health plans. This also conforms to previous DOJ policy.

- **Risk sharing** – The DOJ/FTC requires that networks within the safety zone evidence risk sharing by physicians. Risk sharing is defined to include capitation or fee withhold arrangements. The AMA believes risk sharing should be defined to include an equity interest in the joint venture network itself by member physicians.

Physician input into managed care plans

Most managed care plans have health care networks that are organized and directed by nonphysicians. The AMA believes participating physicians in these plans, meaning those who have a contractual relationship with it, should have an opportunity for input into the plans about their policies. The public will benefit from this input because much of it is likely to be in the interest of patients.

Participating physicians should have input in two ways. First, committees elected by participating physicians should be created to address medical review and quality assurance criteria and

Antitrust: A comparison

AMA

Safety zones for

- non-exclusive networks limited to 50% of MDs by specialty (2 MDs from each specialty, if above criteria can't be met)
- exclusive networks limited to 35% of MDs by specialty

Competitiveness based on number of MDs as a percent of all MDs in area health plans.

Risk sharing

- safety zones for unintegrated groups of MDs
- additional protection for peer review, standard setting
- include equity interest by MDs

MD input into non-MD directed plans

- medical review
- quality assurance
- MD credentialing
- administration

Negotiation with government programs on

- premium targets
- reduction in payments if targets aren't met
- national quality performance standards
- capitation & fee withhold

DOJ/FTC*

Safety zones

- 20% of MDs by specialty (one per specialty if too few MDs to meet 20%)

Competitiveness based on MDs in network as a percentage of total MDs in market

Risk sharing must include capitation/fee withhold

Networks outside safety zones

- 'Rule of Reason' analysis
 - MDs must share financial risk
 - network must offer new products, substantial efficiencies

Safety zone for MD input into non-MD directed plans

- collection of medical data includes mode, quality, efficiency
- for medical society collection of outcome data
- MD development of practice parameters
- hospital mergers
- joint ventures for high-tech equipment, services
- joint purchasing arrangements

* Department of Justice/
Federal Trade
Commission

The Health Security Act (Clinton plan-Section 1322)

Includes DOJ/FTC statements

In addition

- exempts fee negotiation process with providers in fee-for-service plans and fee-for-service segments of HMO and PPO plan
- Alliance or state has ultimate authority to set fee schedules

Hatch (S 1658), Archer (HR 3486)

Exempts

- MD networks of $\leq 25\%$ of total specialists in market (Hatch is $\leq 20\%$)
- standard setting, enforcement to promote health care
- MD participation in surveys of prices, reimbursement if:
 - conducted by third party
 - data is \leq three months old
 - data is aggregated
- hospital mergers
- joint ventures for high tech equipment, services
- joint purchasing arrangements
- negotiations to carry out "safe harbor" activities

Networks outside of safe harbors

- requires attorney general to solicit proposals for additional safe harbors
- provides for certificates of review

"Rule of reason"

- provides process for joint ventures to be considered
- must be non-exclusive network with $\leq 50\%$ MDs in area, $\leq 50\%$ specialties in area
- exclusive network limited to 35% of providers and 35% of specialty in area

procedures, physician credentialing criteria and procedures, administrative issues such as claims procedures and patient treatment and outcome reporting, and physician payment.

In addition, participating physicians should be allowed to develop and present joint presentations to the health plan, provided they do not threaten or implement a boycott. This kind of activity has been recognized as valid by several federal court decisions, including the Alston case. The DOJ/FTC have opposed creating a safety zone for this kind of activity when it involves fee-related information. They are concerned that the provision of fee-related information could lead to price fixing, even though it is legal to provide such information. This should not be a cause for concern if the activity is restricted to the provision of information that the plan is free to accept or reject, and if the activity is restricted to physicians who participate in the health plan.

Unintegrated groups of physicians

There will continue to be health plans that do not have contractual relationships with physicians. The AMA believes unintegrated physicians should be allowed to present positions to these payers about their policies, including the same issues described above for physicians who have contractual relationships with a plan. Again, this kind of activity has been recognized as being legitimate by federal court decisions, including the Alston case. The AMA believes that a safety zone should exist for it.

The DOJ/FTC oppose the creation of safety zones for the

provision of price-related information. They fear that it will lead to price fixing. However, the AMA believes there is little reason to be concerned, provided that the payer is free to accept or reject the positions advanced by the physician group. The AMA proposal would not allow physicians engaging in this kind of activity to threaten or implement a boycott. In addition, to prevent implicit conspiracies achieved by price signaling from occurring, the AMA proposal would not allow independently practicing physicians in the network to exchange information concerning their usual charges, except on an aggregate or composite basis that does not reveal the charges of any individual physician. This protection is consistent with DOJ/FTC policy on exchange of price and cost information by hospitals.

The AMA also believes that where a dominant payer has more than 50% of a market, unintegrated physician groups should be able to negotiate payment levels with the payer. There is little risk of anticompetitive effects provided that no such group accounts for more than 35% of the market. The AMA proposes that a size limit be set on the number of physicians who would be allowed to engage in these activities. The size limit would be 35% of physicians practicing in the relevant geographic market. This size limit is consistent with the positions of leading antitrust theorists in the "Chicago School" of law and economics.

Standard setting and peer review
Physicians will be asked to participate in an increased amount of standard setting and peer review in the health care system of the

future. In spite of the provisions of the Health Care Quality Improvement Act of 1986, there continues to be a substantial amount of litigation over standard setting and peer review decisions. Physicians who participate in these activities, usually on a voluntary, unpaid basis, continue to be named defendants in litigation. In addition, medical societies that engage in standard setting and peer review continue to be sued. The threat of expensive litigation is a significant deterrent to effective standard setting and peer review by physicians and medical societies.

The AMA believes additional protections should be extended to physicians and medical societies that engage in standard setting and peer review. These protections should include an exemption for these activities from private antitrust actions (but allowing federal and state enforcement agencies to sue for injunctive relief) and the shifting of attorneys' fees to any private party that sues on the basis of activities that fall within the scope of the exemption. Standard setting and peer review activities would not include the regulation of truthful advertising or the review of fees. False advertising and fee gouging would continue to be subject to standard setting and peer review.

The Health Security Act

The president's proposed Health Security Act does not provide for a true competitive market. It calls for competition on the seller side of the health care services and insurance market, but it does not call for competition on the buyer side. Instead, it calls for the formation of monopsony purchasers (the health alliances) backed up

by a substantial amount of regulation of health plans and providers. The lack of competition on the buyer side will inevitably lead to distortions in the market.

Given the lack of competition on the buyer side and the heavy degree of regulation, physicians should be allowed to negotiate with the government on such issues as the national per capita baseline premium target, the regional alliance per capita baseline premium target and the methods used to arrive at adjustments of those targets. Physicians should also be allowed to negotiate reductions in payments made as a result of failure to meet the premium targets and similar issues. The national quality performance standards and the administrative demands placed on physicians to implement the outcomes monitoring and reporting that are to be part of the National Quality Management Program should be the subject of negotiations. Finally, physicians should be allowed to negotiate guidelines for capitation

and withhold arrangements.

Section 1322 of the proposed Health Security Act (Clinton plan) is a good start and provides a model for what could be handled in a more comprehensive way by extending the negotiations authorization to other issues. As it stands, the negotiations authority of Section 1322 is very limited. Although physician organizations will be allowed to negotiate the fee schedule for the fee-for-service plans with an alliance or with a state, they will be allowed to do so only after the overall per capita baseline premium target for the alliance has been decided, and the physician organizations will have no voice in the setting of that target.

There are also some technical corrections in Section 1322 that could be made. First, the section appears to contemplate that physician organizations will be allowed to negotiate with a state if a state decides to set a statewide fee schedule. However, that requirement needs to be made more ex-

pressly.

Second, there is no requirement that an alliance or a state negotiate with physician organizations in good faith. It may be possible for an alliance or a state to set a fee schedule, and then go through the motions of negotiating with a physician organization without intending to modify the schedule in any way as a result of those negotiations, although a federal act prohibits a government agency from doing so.

Third, there should be processes such as mediation or arbitration to resolve deadlocks. That would help to assure that the negotiations are carried on in good faith.

Finally, the validity of the exemptions provided would be buttressed if alliances were considered to be government agencies or to be acting on behalf of government agencies. □

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Public opinion on tobacco use, its taxes and public policy

Mohammad R. Torabi, Ph.D.,
M.P.H.

Larry McAllister, B.S.

Jerome E. Kotecki, H.S.D.

Public opinion is an important vehicle in shaping legislative efforts and public policy relating to tobacco use and its related taxes. Researchers have studied the effect of state cigarette tax increases on cigarette sales in the 50 states for the years 1955 to 1988. Generally, larger tax increases were associated with larger declines in consumption of cigarettes.¹ Another study was designed to evaluate the impact of the 1989 California cigarette tax increase on use of cigarettes among adult residents of the state. Analysis of the data revealed a sharp drop trend in California cigarette consumption co-incident with the increase of the tobacco related tax.²

The serious effects of cigarette smoking on health are well-documented. More than three decades of research on the health consequences of smoking have produced eye-opening results,³ leading a former surgeon general of the United States to state that smoking is the most single avoidable cause of death in our society.^{4,5}

Furthermore, the relationship of individuals' opinions and practices regarding the sale of tobacco in a hospital setting⁶ and pharmacy stores⁷ are documented in literature.

This study examined public opinion about policy related to tobacco use and raising tobacco

taxes in a Midwestern state. Additionally, the relationships of gender, educational background and income to the subjects' opinions about the various aspects of tobacco, taxes and related policies were examined.

Methodology

The American Lung Association of Indiana provided a grant to sponsor this project. A structured questionnaire was developed, field tested and revised for the final data collection procedure. A representative sample of 800 adult subjects was selected randomly and interviewed by telephone by representatives of the Indiana University Center for Survey Research. The study population was

Abstract

Public opinion is an important vehicle in shaping legislative efforts and public policy related to tobacco use and related taxes. This study examined public opinion about policy related to tobacco use and raising tobacco taxes in a Midwestern state. The American Lung Association of Indiana provided a grant to sponsor this project. A structured questionnaire was developed, field tested and revised for the final data collection procedure. A sample of 800 adult subjects was randomly selected and telephone interviewed by the Indiana University Center for Survey Research. The collected data were subjected to descriptive and inferential statistics. The data revealed a good representative sample of adult males and females for various age groups and socioeconomic backgrounds. Among other findings, 29% were currently smokers, 23% were former smokers, and 47.5% never smoked. More than 90% support a requirement that public places have nonsmoking areas. About 85% favor an increase in cigarette taxes to pay for health education and tobacco-related research. The relationship of the subjects' gender, education and income to their opinion about the various aspects of tobacco, taxes and related policies were examined.

adult (18 and older) residents of Indiana. The results have a margin of error of 4% at the 95% confidence interval. The collected data were subjected to descriptive and inferential statistics. The data revealed a good representative sample of adult men and women for various age groups and socioeconomic backgrounds.

Findings

Of 800 selected, 754 adult subjects participated in the study. Forty-five percent were men, and 55% were women. Their ages ranged from 18 to older than 65 years old. Most of them (40%) were between 30 to 44 years of age, and most were employed. About 61% were married, more than 17% never

married, about 20% were divorced or widowed, and the remaining were cohabiting or separated. About 42% had no children, 19% had one, 26% had two, 10% had three, and more than 3% had four children.

With regard to the subjects' educational level, nearly 50% had a high school diploma or less, and the remaining completed some college or even graduate degrees. Nearly 36% of the participants reported a total household income of less than \$25,000, and the remaining 65% earned \$25,000 or more.

This study revealed that about 29% currently smoke cigarettes, cigars or pipes, 23% were former

smokers, and 48% never smoked. Of those who use tobacco, 94% were cigarette smokers. More than 70% of the smokers smoke one pack or more cigarettes a day, and 30% smoke less than a pack.

The participants were asked, "Would you favor or oppose legislation that would fund educational programs to help prevent young people from starting to smoke?" Their response was about 89% in favor, 10% opposed, and 2% undecided (*Figure 1*).

The participants were asked if they favored or opposed a tax increase on cigarettes if the funds were used for educational programs on tobacco-related disease. As *Figure 2* shows, nearly 86%

favored a tax increase on cigarettes if the funds were used for educational programs on tobacco-related diseases, and about 14% opposed it. About 38% favored a tax increase of five cents or less per pack, 26%, 10 cents; 14%, 20 to 25 cents; and 14%, 50 cents or more.

Figure 3 shows that 75% favored a tax increase on cigarettes if the funds were used for research on tobacco-related diseases and 25% opposed such a tax.

Subjects also were asked whether or not they favored having required nonsmoking areas for public places. As *Figure 4* shows, most (93.4%) strongly or somewhat agreed that restaurants,

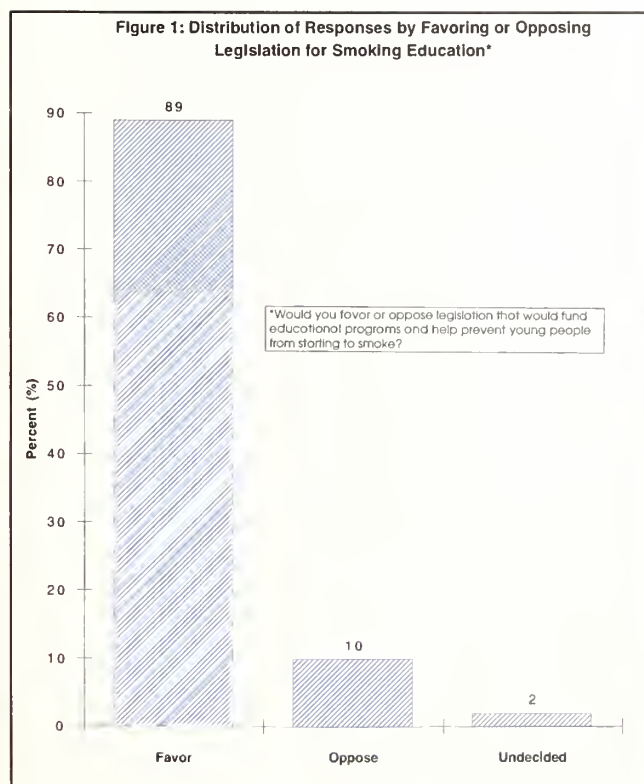


Figure 1

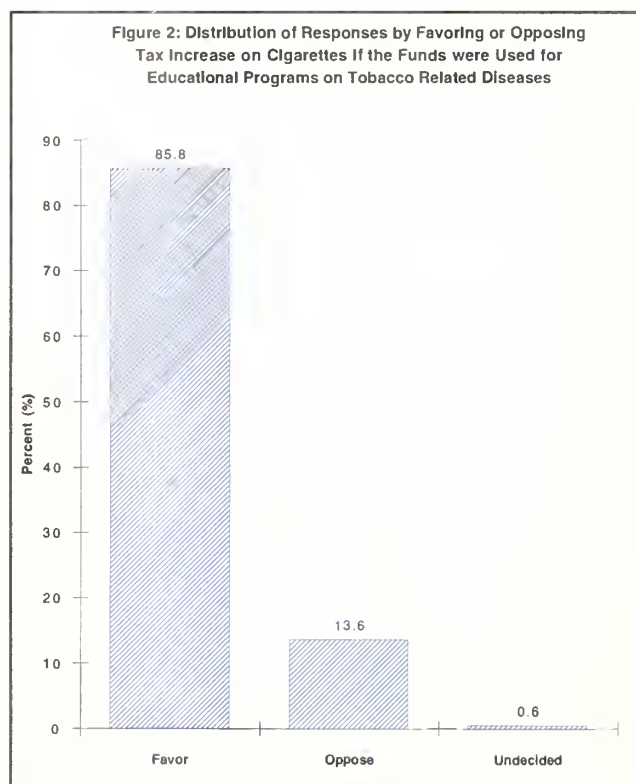


Figure 2

lobbies and other public places should be required to have non-smoking areas, and the remaining (6.6%) strongly or somewhat disagreed with the policy.

The participants also were asked if raising the taxes on cigarettes would discourage people from starting to smoke. Their responses were very perceptive in that they agreed with other authorities.⁸ About 60% of the respondents strongly agreed or somewhat agreed that raising taxes on cigarettes would discourage people from starting to smoke, and the remaining 40% somewhat disagreed or strongly disagreed.

About 91% of the participants agreed or strongly agreed that smoking causes cancer, and the

remaining 9% somewhat disagreed or strongly disagreed (Figure 5).

As Figure 6 shows, nearly 90% strongly agreed or somewhat agreed that second-hand smoke is a health threat, while 10% somewhat disagreed or strongly disagreed.

In order for the government to pay for educational programs to help prevent young people from starting to smoke, how should these programs be financed? More than 11% responded that the government should raise taxes, 82% said cut spending, more than 3% favored borrowing the money, and the remaining 4% were undecided.

Chi-square statistical tests were used to test the relationship

between tobacco use and support for an increased cigarette tax with the following: gender, age, income, educational background and employment status.

There were statistically significant relationships between smoking behavior with gender ($p < .01$), with age ($p < .01$), with income ($p < .05$) and with educational level ($p < .01$). This indicates that individuals were more likely to smoke cigarettes if they were female, young, earned a low income and had a low educational background. However, no significant relationships existed between gender, age, income, educational background, employment and their opinion about raising the cigarette tax ($p > .05$). Additionally, corresponding nonsignificant

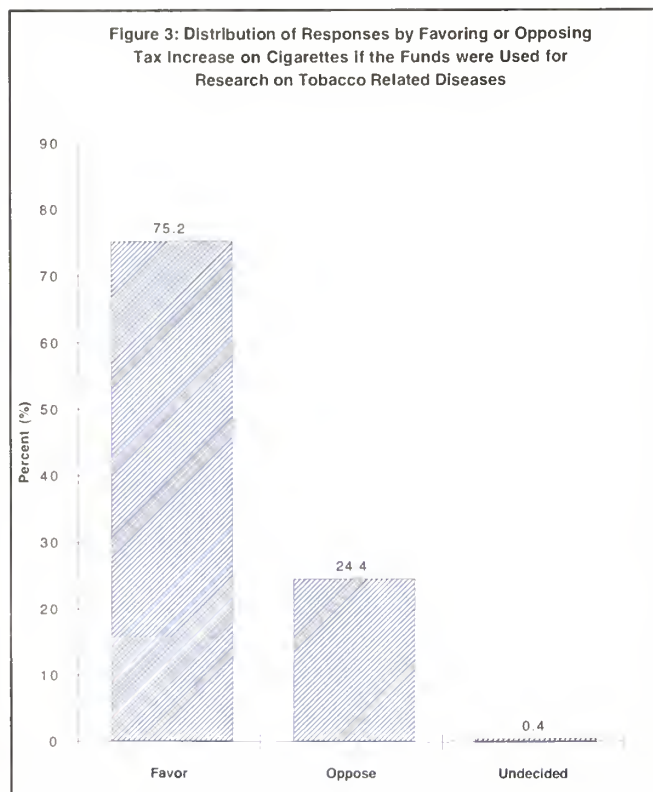


Figure 3

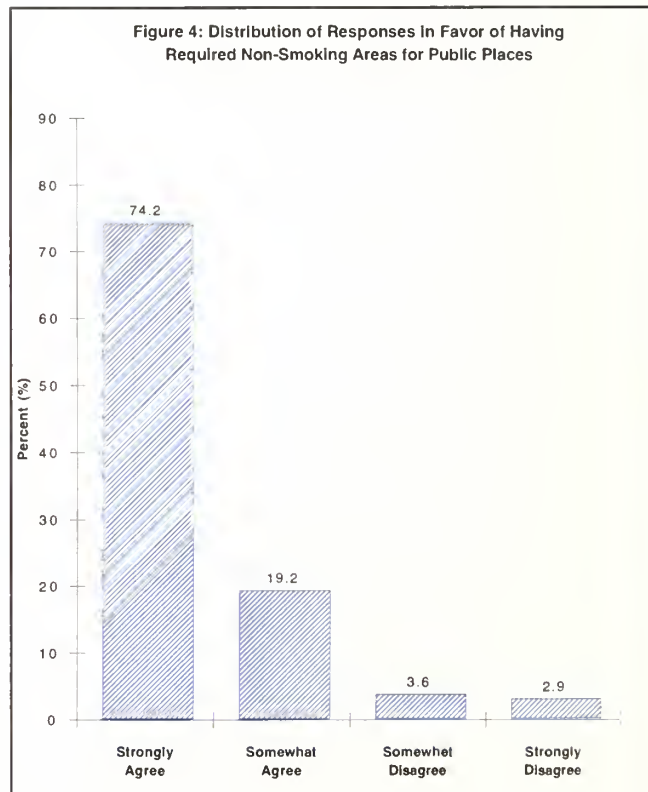


Figure 4

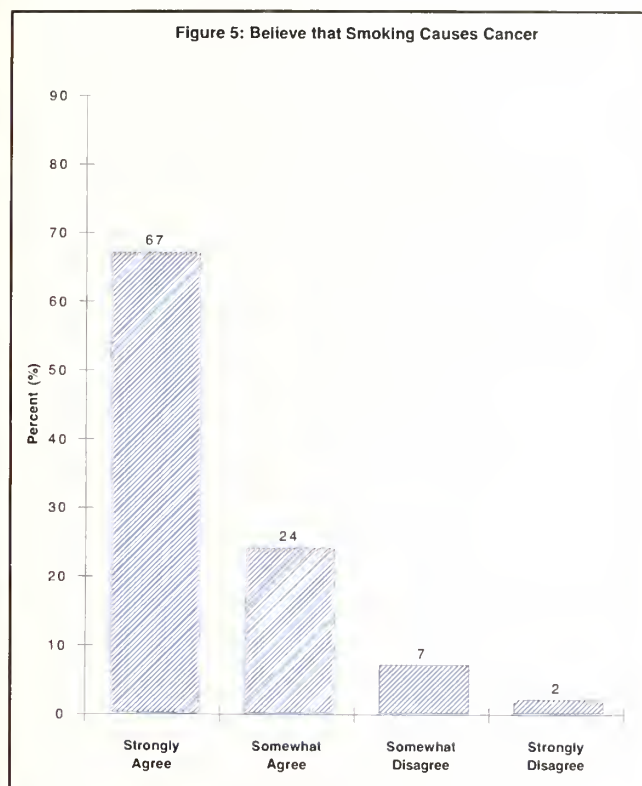


Figure 5

relationships existed with each of these variables and having a required nonsmoking section in public places ($p > .05$).

Further, chi-square test revealed that gender was statistically related to the opinion that raising tobacco tax reduces smoking ($p < .01$). In addition, younger people, higher income earners and individuals with a higher educational background were more likely ($p < .01$) to believe that smoking causes cancer.

Discussion and conclusion

The findings of this study revealed interesting information for health professionals in general and public health educators specifically. For example, less than one-third of the adult population

in Indiana smoke cigarettes; however, less than a quarter of residents have become former smokers.

Public opinion strongly favors legislation that would fund smoking educational programs targeting young people. State legislators need to be cognizant of these data, which provide them with further reassurance to take action on this issue. Furthermore, the general public of Indiana, who for the most part have a low educational background, think progressively and value educational programs and research on tobacco-related diseases. Significance testing also revealed that this opinion was constant across various demographics, such as gender, income, education and em-

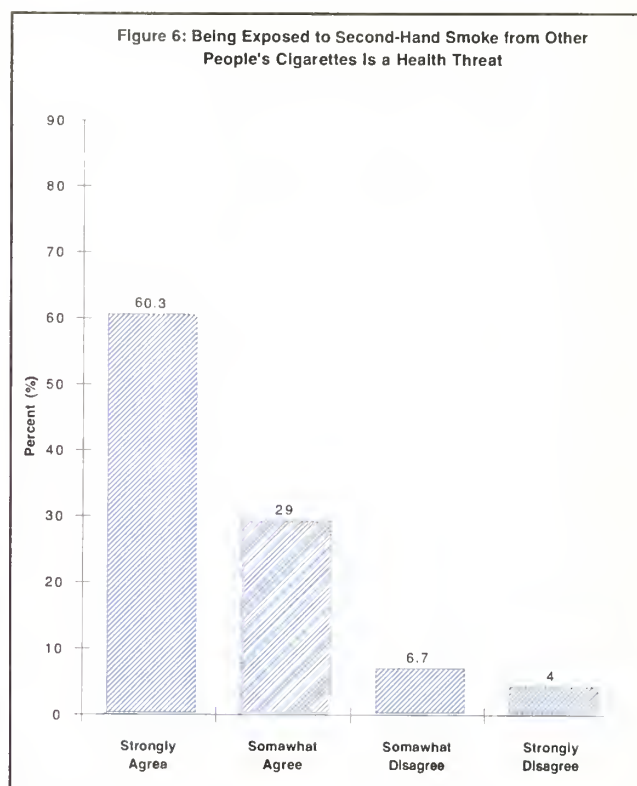


Figure 6

ployment status.

In addition, Indiana residents have recognized the health consequences of second-hand smoke. Thus, most agreed that restaurants and other public places should be required to have non-smoking areas.

Recommendations

The following recommendations are based on the findings of this study for the state of Indiana.

To continue to advance toward the U.S. health objectives on smoking, expanded educational programs are necessary, requiring increased funding. One way to increase money is to raise the tobacco tax from the current 15.5 cents per pack of 20 cigarettes⁹ to 40.5 cents per pack of cigarettes.

This 25-cent tax raise on cigarettes is similar to the amount the state of California raised its cigarette tax in 1987.

The revenue generated through this means could be used for promoting an educational program related to tobacco and research on tobacco-related diseases. The allocation of funds in this manner would be congruent with the public's opinion on how such money should be used.

Indiana ranked 10th highest in the country in the percentage of current adult smokers in 1987,¹⁰ the last year that Indiana raised its cigarette taxes. Between the years 1987 and 1990, no significant changes were observed in smoking rates in Indiana. This information is of considerable concern among state, community and volunteer health education agencies. With increased resources available through a state

cigarette tax hike, increased focus on tobacco education for adults could be substantiated and maintained. □

Dr. Torabi is a professor in the Department of Applied Health Science at Indiana University. McAllister is managing director of the American Lung Association of Michigan, and Dr. Kotecki is a visiting assistant professor at the University of Northern Iowa.

Correspondence: Mohammad R. Torabi, Ph.D., Indiana University, Department of Applied Health Science, HPER Building 116, Bloomington, IN 47405.

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Four steps for qualified plan distributions

Joel M. Blau, CFP
AMA Investment Advisers Inc.

If you are acting as the administrator or are responsible for your qualified plan (i.e., pension, profit sharing, 401(k), etc.), you should know what to do when an employee requests a distribution. A distribution typically is done when an employee retires or stops working for an organization. Administrators are required to give a written explanation to participants who are about to receive a distribution from a qualified plan. This explanation should cover four major topics.

First, you should explain any special tax treatment for lump sum distributions that may be available to the participant. Depending on the employee's age, he may be able to take advantage of five-year or 10-year forward averaging to spread out his in-

come tax liability. Next, if the employee is under age 59 1/2, you should spell out the potential 10% IRS penalty on early withdrawals. Third, you should explain Regular Rollover Rules. If the plan distributes directly to the participants, they have 60 days to roll the funds into an IRA to defer the tax. Unfortunately, the distribution will be subject to mandatory tax withholding. That leads us to your fourth and most important topic – the explanation of the new mandatory withholding rule and the preferred alternative.

The plan administrator is required to withhold 20% of the plan distribution, even though the employee plans on doing an IRA rollover within the 60 day period. Withholding is a major disadvantage to the participant since the IRS won't refund the 20% withheld until the following year. Additionally, to complete the rollover, employees must use their

own additional funds to make up the 20% that was withheld.

To avoid the mandatory withholding rule, the administrator must notify employees about the advantage of a direct rollover option. Under this option, the distribution is made directly to the new IRA or qualified plan. This method avoids the withholding rule and stills defers taxation. Additionally, it forces participants to research the alternatives before distribution is made. If you use a third-party administrator, make sure he gives your employees the options as well as a sufficient amount of time to conduct research.

The IRS has issued sample text that can be used to satisfy the required explanation in Notice 92-48, I.R.B. 1992-45, 25. □

The author welcomes readers' questions. He can be reached at 1-800-262-3863.

ARNETT CLINIC

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In seven outpatient facilities, over 100 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The majority of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 320,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Hame Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates:

- Cardiology
- Dermatology
- Family Medicine
- General Internal Medicine
- OB/GYN
- Oncology
- Orthopaedic Hand Surgeon
- Pediatrics

Practice Setting

At this time, over 100 physicians work for Arnett Clinic. One of the most practi-

cal reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information

Please contact: Physician Recruitment Department
Arnett Clinic, 2600 Greenbush Street
Lafayette, IN 47904 (317) 448-8000
Toll Free Nationwide, 1-800-899-8448



Lafayette, Indiana

Physician stitches award-winning quilts

Tina Sims
Managing Editor

Joyce Byllesby, M.D., can't imagine life without quilting. "It's my real passion these days," she says.

Her first clue that she'd become so hooked on quilting came in 1962 when she was a medical student. "I was supposed to be studying, but I made a quilt instead," she says. The crib quilt was an "Alice in Wonderland" pattern that she made for a niece.

Not until 13 years later did she start quilting again. In between, she was too busy completing medical school and her residency and starting a practice to pursue a hobby.

Now she always has a project

under way, and other ideas are taking shape in her mind. "I have enough ideas to last my lifetime and several more," says the Washington, Ind., pathologist.

Because it's the process of creating a quilt – not the prospect of owning a completed quilt – that brings her the most satisfaction, she gives most of her quilts away to family members or friends. This also reflects her practical side. "I'm so pragmatic. I don't just make quilts to make quilts. I have to make it for somebody or something."

After a friend bought a new brass bed, for example, Dr. Byllesby offered to make a quilt in a pattern of the friend's choice, Cathedral Window. After Dr. Byllesby spotted the Log Cabin Sampler pattern in a magazine,

she knew she "had to make it for someone," so her sister gladly accepted the offer, stipulating only that it had to be predominantly gray. Dr. Byllesby's sister was so pleased with the finished piece, which included accent colors of blue and red, that she re-decorated her bedroom using the quilt as the focal point.

Another of Dr. Byllesby's quilts, this one in the Hidden Wells pattern, inspired the color scheme in a bedroom when a cousin who received the quilt moved to a new house.

Several of Dr. Byllesby's quilts represent two or three generations of stitchery. The Sweet 16 quilts that cover twin beds in her home include 35 quilt blocks made by her grandmother, who died in 1949, a few days before Dr. Byllesby's 16th birthday. Knowing that she would need more than the 35 original blocks, Dr. Byllesby in 1975 made enough blocks for two twin-size quilts. Sometime during the 1930s, her grandmother had stitched a pattern known as Building Blocks into a quilt top. In 1986, in a joint effort to finish the quilt, Dr. Byllesby's mother took the quilt top apart, and Dr. Byllesby pieced the blocks together in a queen-size quilt that was a gift for her nephew and his wife.

She and her sister have teamed up on some other quilting projects, including a California desert scene, designed by Dr. Byllesby's sister, that features palm trees, cactus and a road runner. "I'm not the designer. I admire people who are," Dr. Byllesby says. Another sister embroidered blocks of birds and



Dr. Byllesby works on her Irish Eyes quilt, which will be given to an Irish friend in Portland, Ore.

flowers that Dr. Byllesby stitched into another quilt that won first place in the Santa Barbara, Calif., fair.

Dr. Byllesby has won other prizes for her work. The Floral Fanfare quilt earned second place in the Indiana State Fair and first prize and the grand champion award at the Daviess County Fair.

Her version of Flowers for a Friend merited the grand champion award in the Daviess County Fair and the Viewers Choice Award at a quilt show in Owensboro, Ky. That quilt, appropriately enough, was stitched for a friend, who insisted on paying Dr. Byllesby for her labor.

When Dr. Byllesby suggested that the friend instead make a donation to her two favorite charities, the Salvation Army or the Quilters' Hall of Fame, the friend contributed to both.

Dr. Byllesby is always looking for new pattern ideas. She relies heavily on Quilters' Newsletter Magazine and also finds inspiration at quilt shows and contests. "If there's a quilt show in the area and I can get there, I'll be there," she says. She made the Flowers for a Friend quilt after seeing an exhibit of the works of Marie Webster, an Indiana resident who led the quilt revival in the early 1900s, and admiring her floral applique.

Dr. Byllesby's red, white and blue Stars Etc. wall hanging was displayed at Union Station in Indianapolis in 1987. It was designed for a quilt contest sponsored by *The Indianapolis Star*, which exhibited the entries in the renovated train depot.

One quilt among her works has a foreign connection. During



Dr. Byllesby poses with her Iris Fantasy quilted wall hanging, which she gave to a relative.

a visit to Malaysia, Dr. Byllesby's mother bought a batik material featuring what Dr. Byllesby calls a Christmas tree ornament design. "I sandwiched it together quilt-style and bound it with a piece of red fabric," creating a wall hanging for a niece in Michigan, she says.

"Quilts are made to be used," Dr. Byllesby maintains. They should not be left folded up for years in a closet, she says, because the fabric along the folds will eventually break down. She wants her creations to cover a bed or decorate a wall or even to be worn. Her wearable quilted works include jumpers for relatives and a jacket and a dress for herself.

The garment of which she is the proudest, however, is a sweater jacket that could have fetched several hundred dollars. Dr. Byllesby's sister was wearing the quilted jacket, made from some yarn Dr. Byllesby bought on sale, in the Palm Springs, Calif.,

airport when a man approached her and offered to – literally – buy the jacket off her back for his wife. Despite his pleas, Dr. Byllesby's sister refused to sell, preferring not to cash in on her one-of-a-kind fashion.

Dr. Byllesby, a self-taught quilter who didn't take her first quilting class until two years ago, has always been handy with a needle and thread. She learned how to knit and embroider from her mother and sewed all her clothes during medical school. In between quilting projects, she still occasionally knits, embroiders and works on counted cross-stitch projects.

Since she retired as pathologist at Daviess County Hospital in Washington, she has been doing locum tenens work and overseeing the construction of a new house in the Indianapolis area. In preparation for her move, she has already researched the meeting schedules of Indianapolis quilting groups. □

Surgical management of atrial fibrillation: The maze procedure

Editor's note: See related editorial on page 114.

Daniel J. Beckman, M.D.
Maria Evans, R.N.
Maria Bandy, B.S., P.A.
Barry Crevey, M.D.
Indianapolis

Atrial fibrillation is a common arrhythmia occurring in 0.15% to 1.5% of the U.S. population.¹ The relative frequency increases with age, such that ap-

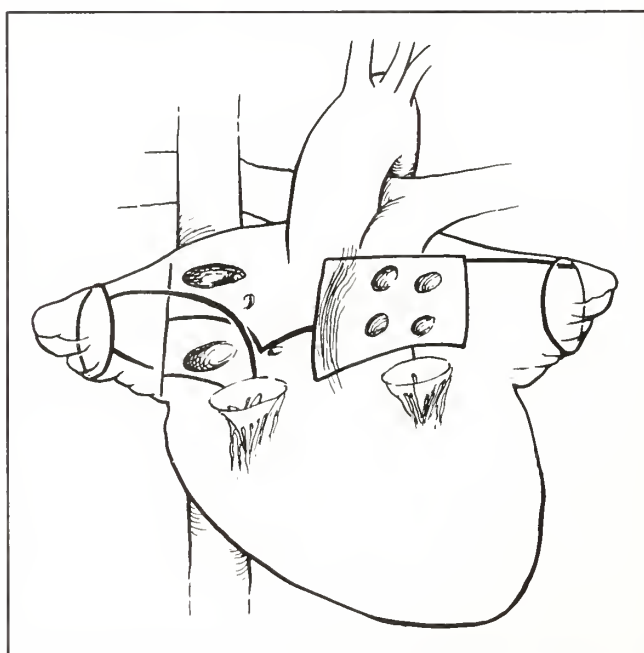
proximately 10% of the population over 60 years of age has atrial fibrillation.² The adverse clinical sequelae resulting from atrial fibrillation are: 1) irregular heart beat; 2) hemodynamic compromise; and 3) thromboembolism. Thromboembolism remains the most dramatic and lethal complication. One-third of all patients with chronic atrial fibrillation develop thromboembolism. Seventy-five percent of thromboembolic phenomenon associated with chronic atrial fibrillation

involve the brain. Sixty percent of thromboembolic neurological events associated with chronic atrial fibrillation result in death or permanent severe neurological deficits.³

Sustained conversion of atrial fibrillation to normal sinus rhythm by medical means is notoriously poor. Pharmacologic therapy is primarily directed toward rate control.⁴ Rate control does not alleviate the untoward effects of an irregular rhythm. Furthermore, rate control does not correct the adverse hemodynamic effects or ameliorate the increased propensity toward thromboembolism. Destruction of the His' bundle by catheter ablation and implantation of a permanent pacemaker likewise control the rate and irregular rhythm but do not correct the other physiologic perturbations associated with atrial fibrillation.

Multipoint mapping of the atrium indicates that large areas of contiguous atrial tissue are necessary to produce macroreentry and thus sustain atrial fibrillation.⁵ Surgical therapy involves segmenting the atrium into smaller blocks of electrically continuous tissue. This division creates an electrical maze that allows complete activation of the atrium but prevents macroreentry. The critical mass of atrial tissue re-

Figure: Atrial incisions for the maze procedure.



Table

Indications for the maze procedure

1. Chronic atrial fibrillation poorly controlled with medical therapy
2. Intolerance to conventional therapy
3. Occupation requires freedom from cardiac arrhythmia (e.g., airline pilot);
4. Patients at high risk for thromboembolic problems with contraindications to anticoagulant therapy
5. Frequent episodes of paroxysmal atrial fibrillation leading to acute hemodynamic deterioration not prevented by medical therapy
6. Patients undergoing mitral valve surgery with chronic atrial fibrillation not likely to retain normal sinus rhythm postoperatively

quired for macroreentry to occur is determined by the absolute refractory period. The incisions of the maze procedure for atrial fibrillation reduce the critical mass of contiguous atrial tissue, within the restraints of the normal absolute refractory period, to below the threshold required for macroreentry to occur. The maze procedure for atrial fibrillation restores normal sinus rhythm and atrial transport function and decreases the risk of thromboembolism.⁶ Surgical management of atrial fibrillation is appropriate in select cases as the following case report illustrates.

Case report

The patient was a 56-year-old woman with paroxysmal atrial fibrillation. She had multiple admissions to the emergency department for uncontrolled ventricular response. Her past medications have included digoxin, procainamide, disopyramide phosphate, propranolol hydrochloride, warfarin, amiodarone hydrochloride, quinidine and verapamil hydrochloride. Physical examination and laboratory studies including thyroid functions were normal. Catheterization revealed normal coronary

arteries and normal ventricular function. Echocardiogram revealed no valvular heart disease. After the patient underwent the maze procedure, she recovered from surgery and is free of atrial fibrillation.

Operative technique

The maze procedure requires cardiopulmonary bypass. Twelve atriotomies are performed and four cryoprobe lesions are placed (Figure). These incisions allow the electrical impulse to spread throughout the atrium and reach the atrioventricular node. The incisions however, prevent the electrical impulse from turning back upon itself and establishing a reentry circuit. Once an electrical impulse originates from any point within the atrium, it cannot reenter that point again without crossing a suture line.⁷

Discussion

The indications for the maze operation are listed in the Table. Further expansion of the operative indications awaits long-term clinical experience. The annual mortality rate due to chronic atrial fibrillation in young patients without significant heart failure is 2.6% to 8.0%.⁴ If the operative

mortality of the maze procedure is maintained at less than 2%, expansion of the operative indications to include all young patients with chronic atrial fibrillation of greater than one year duration would seem justified.

Surgical management of atrial fibrillation eliminates all three of the adverse physiologic consequences of atrial fibrillation. Therefore, it may improve quality of life by enhancing cardiac output and decreasing morbidity and mortality due to thromboembolism.⁵⁻⁷ □

Dr. Beckman, Ms. Evans and Ms. Bandy are with the Department of Cardiovascular Surgery, and Dr. Crevey is with the Department of Cardiology at Methodist Hospital in Indianapolis.

Correspondence: Daniel J. Beckman, M.D., Methodist Professional Building, Suite 755, 1801 N. Senate Blvd., Indianapolis, IN 46202.

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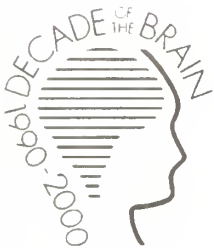
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ISMA Alliance plans 50th annual convention

Sue Ellen Greenlee, ISMA Alliance president
Lucy Reed Foltyniak, corresponding secretary

ISM Alliance members will converge at Amish Acres in Nappanee April 13, 14 and 15 for

the 50th annual Alliance convention. This 50th-year celebration will be the last Alliance convention as we have known it to be. Next October and each year thereafter, the Alliance and the ISMA will jointly host an annual convention for their members.

Amish Acres is a lovely area

offering charm, wholesome food and an old-world experience. The April convention will be hosted by the Noble LaGrange County Medical Alliance. The days and evenings will be fun, informative and, more than anything else, a celebration. Please come and participate. □

Tentative convention agenda

Wednesday, April 13

noon - 5 p.m.	Registration	3 p.m.	
noon - 2 p.m.	Set up exhibit area		
1 p.m.	Finance committee meeting	4 p.m.	
1:30 p.m.	Board of directors meeting		
2 p.m.	Convention opening - first session		
2:30 p.m.	Reference committees		
4:30 p.m.	Free time for buggy ride, browsing, tours	6 p.m.	
6 p.m.	Dinner in honor of former ISMA-A presidents		
	Speaker: Shelli Yoder, Miss Indiana 1992, "Eating Disorders - Her Own Story"		

Thursday, April 14

7:30 a.m. - 5 p.m.	Registration and exhibit area open	
7:30 a.m.	Breakfast	
7:30 a.m.	Former ISMA-A presidents meeting	
9 a.m.	Second session of convention	
11 a.m.	AIDS in Indiana	
noon	Lunch	11:30 a.m.
	Drama presentation on AIDS by Straightway, a teen group	
1 p.m.	Reconvene second session	

Friday, April 15

7:30 - 11 a.m.	Registration
8 a.m.	Breakfast
9 a.m.	Third session of convention
	County presidents' reports - southern, central, northern
	AMA Alliance speaker
	Election of county delegates to AMA
	Alliance convention in June
	Farewell skit by Noble LaGrange Alliance
	Lunch
	President's speech
	President-elect's speech
	Adjourn until Oct. 21, 22 and 23 in Indianapolis □

■ from the museum

Spring benefit to include performance of 'Social Security'

Oren S. Cooley
Indianapolis

The Indiana Medical History Museum will feature a viewing of Andrew Bergman's hilarious comedy "Social Security" during the museum's second annual spring benefit this April.

The insightful comedy, which examines the dilemmas that occur when a young urban couple receives an unexpected visit from the wife's widowed mother, will play three weekends at the Indianapolis Civic Theatre. The museum's benefit will include the performance Friday, April 15.

A cocktail buffet, which will proceed the play, will begin at 6 p.m. in the theatre's Kitty Pantzer Room. The play will begin at 8 p.m.

"Social Security" (1986) served as the Broadway debut of Andrew Bergman, who before this play's appearance worked as a screenwriter and a novelist for more than 10 years. His works include the films "Blazing Saddles" (1974), "The In-Laws" (1979) and "Fletch" (1985) and the novel *Hollywood and Levine* (1975).

"Social Security" revolves around Sophie Greengrass, a

widow with a walker and some irritating ways. As one character explains, "This woman doesn't just complain; she drips with complaint, like a leaky roof in a thunderstorm."

At the play's beginning, Sophie lives on Long Island, New York, with her lowbrow daughter, Trudy Heyman, and Trudy's equally cloddish husband, Martin. When the Heymans suddenly decide to visit their daughter (who attends college elsewhere), Trudy sees this pending trip as "an opportunity" for Sophie to visit Trudy's sophisticated sister, Barbara.

This unexpected visit from Sophie creates numerous dilemmas that continually disrupt the comfortable and trendy life of Barbara and David Kahn. The couple lives in Manhattan, where they work as successful art dealers.

While visiting the Kahns, Sophie meets Maurice Koenig, a lively 98-year-old painter whose significance the Museum of Modern Art plans to recognize by devoting the entire museum to an upcoming retrospective. Through interaction with Koenig, Sophie transforms from a frump in a housecoat to a gal-about-town in

designer suits.

Tickets for the second annual spring benefit will cost \$50 per person. To purchase tickets, call the Indiana Medical History Museum at (317) 635-7329.

All proceeds will benefit the Indiana Medical History Museum, a private, nonprofit organization dedicated to preserving the heritage of the healing arts in Indiana. As the nation's oldest surviving pathology laboratory, the building, which houses the museum, originally provided physicians in the late 1800s and early 1900s with state-of-the-art facilities in which to study mental and nervous disorders.

Today, the museum, located on the near westside of Indianapolis, uses its more than 15,000 artifacts to educate children and other visitors about the developments that made possible today's advanced medical treatments and health care. Last year, the Indiana Medical History Museum raised more than \$3,000 during the first spring benefit to help fund the museum's educational programs. □

The author is director of the Indiana Medical History Museum.



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■ cme calendar

Child Care Conference

The 29th Annual Multidisciplinary Child Care Conference will be held May 18 and 19 at the Omni North Hotel in Indianapolis. The conference will be presented by the Indiana University School of Medicine.

Topics will include sports medicine, neonatology, nursery issues, general pediatrics, allergy/asthma, pediatric hematology, child development/behavioral pediatrics/learning disorders and pediatric infectious disease.

For registration information, write Richard L. Schreiner, M.D., attn: Mary Ann Underwood, Child Care Conference, Department of Pediatrics, IU School of Medicine, Riley Hospital, Rm. 5867, 702 Barnhill Drive, Indianapolis, IN 46202-5225.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

- Apr. 8-9** - Thoracoscopy for the Chest Physician, University Place Conference Center, Indianapolis.
- Apr. 21-22** - 17th Annual Arthur B. Richter Conference in Child Psychiatry, University Place Conference Center, Indianapolis.
- Apr. 28** - Gastroenterology Update 1994, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology Inc. will present "Progress in Cardiology" May 20 at the

Westin Hotel in Indianapolis.

For more information, call Janet MacAbee, (317) 871-6089.

Neurology Associates

Neurology Associates Inc. will present "What's New in Neurology for Primary Care" March 24 at the Radisson Plaza Hotel, Keystone at the Crossing, in Indianapolis.

For registration information, call Susan Stonebraker, (317) 352-9255, ext. 121.

Midwest AIDS Training & Education

Clinical Training Associates Inc. in association with the Midwest AIDS Training and Education Center in Indianapolis will present "Taking Care of the Whole Patient: A Multidisciplinary Approach to Persons with HIV/AIDS" March 22 in Kokomo and April 13 in Terre Haute.

For details, call your local co-sponsor: Susan Ardrey, Kokomo, (317) 455-9251; or Deborah Barnhart, Terre Haute, (812) 237-3696.

Washington University

The Washington University School of Medicine in St. Louis will sponsor these CME courses:

- Mar. 26** - Molecular & Medical Genetics in Clinical Practice, Washington University Medical Center, St. Louis.
- Apr. 8** - Frontiers in Ovulation Induction, Philadelphia.
- Apr. 23** - Infectious Diseases, The Ritz-Carlton Hotel, St. Louis.
- May 7** - Sleep Disorders for the Primary Care Physician, Adam's

Mark Hotel, St. Louis.

May 20-21 - Cardiothoracic Anesthesia, St. Louis.

May 21 - Controversies in Contemporary Imaging, Marriott West, St. Louis.

For more information, call Cathy Sweeney, 1-800-325-9862.

University of Wisconsin

The University of Wisconsin School of Medicine will sponsor these CME courses:

- May 11-12** - Prevention Screening and Health Maintenance in Primary Care, Concourse Hotel, Madison, Wis.
- May 19-21** - 16th Annual Sports Medicine Symposium, Holiday Inn-West, Madison, Wis.

For more information, call Sarah Aslakson, (608) 263-2856.

George Washington University

The George Washington University Medical Center will present these CME courses:

- June 11-14** - Intensive Review of Internal Medicine, Washington Marriott, Washington, D.C.
- June 11-15** - Second Annual Board Review Course in Family Medicine, Crystal Gateway Marriott Hotel, Arlington, Va.
- June 19-22** - 10th Annual Meeting of the International Society of Technology Assessment in Health Care, Stouffer Harborplace, Baltimore, M.D.

For more information, call (202) 994-4285. □

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■ news briefs

Indiana hospitals rank among top 100 in United States

Five Indiana hospitals are among the 100 top-performing acute care hospitals in the United States, according to a recent study. They are Indiana University Medical Center and Wishard Memorial Hospital, both in Indianapolis; Community Hospital, Anderson; Marion General Hospital; and Floyd Memorial Hospital in New Albany.

100 Top U.S. Hospitals – Benchmarks for Success was published from the findings of a study conducted by HCIA, Inc., a health care information company, and Mercer Management Consulting, an international consulting firm.

Performance was assessed from several financial, efficiency and clinical measures that reflect use of resources, provision of care and quality of outcome, a balance that HCIA and Mercer have found best measures the long-term stability of the institution. The report says the "benchmark hospitals" not only provide high value to their customers but also operate efficiently and invest in their facilities.

First hantavirus case reported in Indiana

Indiana has reported its first case of hantavirus pulmonary syndrome, according to the Indiana State Department of Health.

After a Hendricks County man died of adult respiratory distress syndrome in early January, laboratory tests conducted by the Centers for Disease Control and Prevention confirmed recent infection of hantavirus in the man. The Indiana case of ARDS was caused by the same strain of hantavirus found in the southwest United States.

Hantavirus is usually contracted by breathing aerosolized droplets of feces, urine or saliva from the deer mouse, a field rodent. Person-to-person transmission has not been documented.

Grant to fund analyses of corneal transplant data

The Corneal Research Foundation of America has received a \$110,000 research grant from the Indiana Lions Eye Bank. Francis W. Price Jr., M.D., and William E. Whitson, M.D., are co-directors of the foundation, located in Indianapolis.

Dr. Whitson said the grant will be used to help fund the collection and statistical analyses of pre- and postoperative corneal transplant data worldwide. He said the increased national interest in controlled health care costs places greater urgency on improving the success rate of corneal transplants.

Physicians needed to staff children's diabetes camp

The Indiana Affiliate of the American Diabetes Association is looking for physicians and nurses to staff its summer camp for children with insulin-dependent diabetes.

Camp John Warvel will be held at Camp Alexander Mack campgrounds near Warsaw, Ind., for two one-week sessions, July 9 to 16 and July 16 to 23. Physicians may sign up for one-week sessions or shorter periods of time if their schedules will not permit a one-week commitment.

For more information, call Elaine McClane at (317) 352-9226 or 1-800-228-2897.

PICI employee receives risk management award

Barbara Killila is the 1993 recipient

of the Indiana Society for Healthcare Risk Management (ISHRM) Glenn Troyer Award. The award recognizes Killila, director of risk management and education for Physicians Insurance Company of Indiana (PICI), for outstanding contributions to the field of health care risk management and ISHRM.

Killila was a founding member of ISHRM in 1984 and served as its president in 1986. She is a diplomate of the American College of Healthcare Executives and has published many articles on health care risk management. She is Indiana coordinator of the national Practice Assessment/Quality Improvement program prepared and sponsored by the American Medical Association and conducted jointly in Indiana by PICI and the Indiana State Medical Association.

The Glenn Troyer Award was named for the founder of ISHRM. Troyer was the first recipient of the award, initiated in 1991.

I.U. medical school plans alumni weekend

The Indiana University School of Medicine Alumni Weekend is scheduled May 20 and 21. Most events will be held at the University Place Conference Center in Indianapolis.

The schedule includes a CME program, a 90th anniversary celebration lunch and class reunions on May 20 and the annual alumni meeting, an address by Dean Walter Daly, M.D., and an awards program on May 21.

E. Grey Dimond, M.D., a 50-year alumnus of I.U. and dean emeritus of medicine and provost for health sciences emeritus at the University of Missouri-Kansas City, will be one of the CME program speakers. His topic will be

Surgeon general focuses on children's health problems

U.S. Surgeon General M. Joycelyn Elders, M.D., believes she knows the remedies for health problems plaguing American's children.

Investing in comprehensive health education programs for young people and educating parents about child-rearing are two courses of action that could prevent problems such as drug and alcohol abuse, teen-age pregnancy and violence, Dr. Elders told an audience at Butler University in Indianapolis. She visited the campus Jan. 24 as part of Butler's "Celebration of Diversity 1994 - The Year of the African-American Woman."

"We've been doing too little too late," she said, stressing the need for preventive programs. "We've got to offer our bright young people hope for the future."

Preventable problems she discussed included:

- Teen pregnancy: "Too many of our children are being born to children."
- AIDS: In Washington, D.C., one in 77 high school students tested HIV-positive. "That's a major problem we've got to begin to address."
- Drug abuse: Dr. Elders pointed to studies that show about 50% of young people have tried illicit drugs.



U.S. Surgeon General M. Joycelyn Elders, M.D., speaks at Butler University.

- Violence: "Our children are killing our children."

Dr. Elders said that the one in five U.S. children who grow up in poverty will probably endure years in the "5-H Club" - hungry, healthless, homeless, hugless and hopeless.

Although the United States spends more on health care than any other country in the world, many children still do not receive adequate health care and the United States still ranks behind 19 other industrialized other countries in infant mortality, she said. She also noted that much of the money allocated for health care is actually spent on "very expensive dying."

Besides calling for health edu-

cation for children and better training for parents, Dr. Elders sought the help of churches in upgrading the condition of the nation's children. Because churches have the power and prestige to bring about change, legislators probably would listen to ministers who lobbied for issues concerning children, she said.

She pointed out another group that could help brighten the future of America's children. "We've got to teach our young men to be responsible. There's more to being a father than donating sperm," she said.

During a question and answer period, Dr. Elders said a study needs to be done on the effects of legalization of certain drugs. Although she recently was quoted as supporting the legalization of some drugs, she said she does not favor such an action, only a *study* on the effects of legalization.

She also said public health agencies need to take a more active role in keeping people healthy. "We know when you're born and when you die, but we know little about what happened in between."

In response to a question, Dr. Elders said local school boards will decide whether to distribute condoms in the schools. Dr. Elders has been an outspoken advocate of condom distribution in schools. □

■ news briefs

"Medicine in China."

For information on alumni events, call Claudia Richardson, (317) 274-5060. For information on the CME program, call (317) 274-8353.

Toll-free number offers cancer information

Physicians and their patients with questions about cancer can call the Cancer Information Service (CIS) of Indiana and Michigan. The CIS of Indiana and Michigan is a program of the Indiana University Cancer Center, the Michigan Cancer Foundation and the Prentis Comprehensive Cancer Center and one of 19 regional offices established by the National Cancer Institute to provide local access to cancer information.

Information is available on cancer diagnosis and treatment, screening, primary care services, support groups, second opinions for NCI-sponsored therapeutic trial programs and community supportive services.

Another service is the Physician Data Query (PDQ), a computerized cancer treatment database offering information on cancer, cancer stages and treatment, standard protocols and clinical trial information and a directory of participants in clinical trials in Indiana.

The CIS and PDQ number is 1-800-4-CANCER.

Mother's Day campaign promotes mammograms

The Indiana State Department of Health and the Indiana Division of the American Cancer Society are sponsoring the fifth annual Mammograms for Mother's Day campaign from April 17 to May 14. The campaign encourages women age 40 and older to have a screening mammogram.



Jack Deppe, M.D., left, an Evansville orthopaedic surgeon, talks with Nathan Kaufman during a break at the managed care seminar sponsored by the Indiana State Medical Association. Kaufman, a speaker at the program, is president of the Kaufman Group in San Diego, specializing in helping physicians address the challenges of a new health care system. More than 200 people attended the Jan. 26 seminar.

All mammography facilities in Indiana are being urged to offer mammograms for \$55 or less or to offer free mammograms to low-income women. Only facilities that are accredited by the American College of Radiology or Medicaid certified are eligible. The American Cancer Society, 1-800-ACS-2345, will provide a list of participating facilities.

Physicians who want more information on the program may call Jennifer Ashworth at the health department, (317) 633-0109.

Immunization Week events set April 25-29

National Preschool Immunization Week will be observed April 25 to 29. Several clinics will be organized around the state to help increase the rate of immunizations

by reducing barriers, increasing hours and creating public awareness.

For more information, call Jennifer Ashworth at the Indiana State Department of Health, (317) 633-0109.

Doctors' Day March 30

Doctors' Day, officially established by an Act of Congress in 1933, will be observed March 30.

The day commemorates the day in 1842 when Dr. Crawford Williamson Long became the first acclaimed physician to use ether as an anesthetic agent in a surgical technique. The red carnation has become the official flower of the day, symbolizing recognition and honor to the profession. ┘

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William Beeson, Indianapolis (1995)
Max N. Hoffman, Covington (1994)
C. Dyke Egnatz, Schererville (1994)
Alfred Cox, South Bend (1994)

DISTRICT OFFICERS & MEETINGS

1 - Pres: Rex Ragsdale, Evansville
Secy: John Berry, Evansville
Annual Meeting: May 19, 1994
2 - Pres: Tom Sharp, Bloomington
Secy: Robert Hongen, Bloomington
Annual Meeting: May 12, 1994
3 - Pres: Steve Barlow, Bedford
Secy: Alan Smith, Bedford
Annual Meeting: May 18, 1994
4 - Pres: Barbara Taylor, Greensburg
Secy: Angie Fontanilla, Greensburg
Annual Meeting: May 4, 1994
5 - Pres: James Walsh, Terre Haute
Secy: Rahim Farid, Brazil
Annual Meeting: May 26, 1994
6 - Pres: William Toedebusch, Richmond
Secy: Mark Lemmons, Greenfield
Annual Meeting: May 11, 1994
7 - Pres: Paula Hall, Mooresville
Secy: John Schneider, Indianapolis
Annual Meeting: to be announced

8 - Pres: Susan Pyle, Union City
Secy: Jerome M. Leahey, Union City
Annual Meeting: June 1, 1994
9 - Pres: Irene Gordon, Lafayette
Secy: Stephen D. Tharp, Frankfort
Annual Meeting: June 8, 1994
10 - Pres: John L. Swarner, Valparaiso
Secy: Anil Kothari, Valparaiso
Annual Meeting: April 30, 1994
11 - Pres: William D. Dannacher, Wabash
Secy: Jack Higgins, Kokomo
Annual Meeting: Sept. 14, 1994
12 - Pres: Joseph Manthey, Bluffton
Secy: Brenda Stiles, Fort Wayne
Annual Meeting: Sept. 15, 1994
13 - Pres: Alan H. Bierlein, Bristol
Secy: John W. Schurz, South Bend
Annual Meeting: March 23, 1994

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■ obituaries

Max D. Bartley, M.D.

Dr. Bartley, 74, a retired Indianapolis ophthalmologist, died Dec. 19, 1993, at St. Vincent Hospital.

He was a 1943 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Bartley was in private practice in Indianapolis for 35 years. From 1966 to 1969, he also was head of the ophthalmology department at St. Vincent Hospital. He had been a clinical professor at Indiana University Medical Center and Wishard Memorial Hospital. He was a fellow of the American Academy of Ophthalmology and a board member of the Indiana Society to Prevent Blindness from 1954 to 1960. In 1969, he was named to the Silver Anniversary All-American Football Team by *Sports Illustrated*.

Neal E. Baxter, M.D.

Dr. Baxter, 85, a Bloomington family physician and a leader in aerospace medicine, died Oct. 19, 1993, at Bloomington Hospital.

He was a 1935 graduate of the Indiana University School of Medicine and a Navy flight surgeon during World War II. His experience in treating pilots during the war and his specialization in internal and aerospace medicine led to his appointment as president of the Aerospace Medical Association in 1965. President Lyndon Johnson recognized him for his work in aerospace medicine.

During the 50 years that he practiced medicine in Bloomington, he also served terms as chief of staff and chief of medicine at Bloomington Hospital, Monroe County coroner and

medical director at Westinghouse Electric Co. He was a Sagamore of the Wabash.

Frank J. Brakel Jr., M.D.

Dr. Brakel, 72, a retired Evansville internist, died Dec. 4, 1993, at St. Mary's Medical Center.

He was a 1950 graduate of the University of Nebraska College of Medicine and a veteran of World War II. He saw action on the second day landing on Normandy Beach and was involved in the Battle of the Bulge.

Dr. Brakel was on the faculty at the University of Minnesota from 1954 to 1958 before joining the Welborn Clinic in Evansville. He served as medical director at Good Samaritan Home and was an instructor at the Evansville campus of the Indiana University School of Medicine. Dr. Brakel was a member of the American College of Physicians, the American College of Gastroenterology and the American Geriatrics Society.

Thomas L. Dittmer, M.D.

Dr. Dittmer, 76, a retired Valparaiso general surgeon, died Dec. 9, 1993, at Porter Memorial Hospital.

He was a 1942 graduate of the Indiana University School of Medicine and a U.S. Army Medical Corps veteran of World War II.

Dr. Dittmer shared a medical practice with his brother, Dr. Jack Dittmer, in Valparaiso for many years. He later was an emergency physician at Porter Memorial Hospital in Valparaiso and at Westchester Clinic in Chesterton. Dr. Dittmer's father was a physician, and his son, Dr. Thomas E. Dittmer, is a physician.

James C. Farr, M.D.

Dr. Farr, 75, a Bloomington family physician, died Jan. 2, 1994, at his home.

He was a 1942 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Farr was a founding member of the Paragon Lions Club and a member of Paragon Christian Church.

Robert A. Garrett, M.D.

Dr. Garrett, 74, retired chairman of the urology department at the Indiana University Medical Center, died Dec. 13, 1993.

He was a 1943 graduate of the Indiana University School of Medicine and an Army veteran.

Dr. Garrett was chairman of the medical center's urology department 22 years and was a professor at the IU medical school 37 years. He was recognized for contributions made to pediatric reconstructive procedures and oncology and helped establish a urology department in a new hospital in Pakistan in 1963. Dr. Garrett was honored with the establishment of a mentor campaign and the Robert A. Garrett Visiting Professorship of Pediatric Urology Research.

Lillian S. Holdeman, M.D.

Dr. Holdeman, 83, the retired coordinator of health and psychological services for the South Bend schools, died Nov. 25, 1993, at her home in Fort Myers, Fla.

She was a 1934 graduate of the Indiana University School of Medicine and also received a teaching license and a master's degree in health and safety education.

Dr. Holdeman had a pediatric

practice for several years before joining the South Bend Community School Corp. as health coordinator. In 1969, she was named Woman of the Year by the South Bend-Mishawaka Area Chamber of Commerce. In 1975, the American School Health Association honored her for her work in school health.

Il Ho Kim, M.D.

Dr. Kim, 56, a Kokomo obstetrician and gynecologist, died Dec. 17, 1993, at Indiana University Hospital.

He was a 1963 graduate of the Kyong Puk National University College of Medicine in South Korea.

Dr. Kim was in private practice 21 years. He was a member of the American College of Obstetricians and Gynecologists.

John F. Ling, M.D.

Dr. Ling, 77, a retired Richmond internist, died Jan. 3, 1994.

He was a 1941 graduate of the Indiana University School of Medicine. He received a Bronze Star for his service in the Army Medical Corps during World War II.

Dr. Ling, who had a practice in Richmond from 1949 to 1978, had served as a consultant at Reid Hospital in Richmond and as jail physician in Wayne County. He was past president of the Indiana

chapter of the American Heart Association and served on the association's national board. He was a fellow of the American College of Physicians and the American College of Cardiology.

Jack B. Mershon, M.D.

Dr. Mershon, 73, a retired pathologist, died Dec. 1, 1993, at his home in Monrovia.

He was a 1949 graduate of the University of Tennessee College of Medicine and an Army veteran of the Korean War.

Dr. Mershon was a pathologist at Morgan County Hospital 20 years and owned and operated Mershon Medical Laboratories. Before retiring in 1986, he was a pathologist at St. Elizabeth Hospital in Lafayette 10 years.

Vivencio F. Raymundo, M.D.

Dr. Raymundo, 81, an Elwood surgeon, died Dec. 10, 1993, at Mercy Hospital in Elwood.

He was a 1939 graduate of the University of the Philippines College of Medicine and served as an Army surgeon in World War II.

Dr. Raymundo had been on the staffs at St. Elizabeth Hospital in Lafayette, Williamsport Community Hospital, Bluffton Clinic, Marion General Hospital and Mercy Hospital. He was a member of the American College of Abdominal Surgeons and the Filipino Medical Association.

Charles E. Rutherford, M.D.

Dr. Rutherford, 68, a former Lafayette area surgeon, died Oct. 29, 1993, at his residence in Sun City, Ariz.

He was a 1952 graduate of the Indiana University School of Medicine and a Navy veteran.

Dr. Rutherford was a surgeon 29 years and a general practitioner eight years in West Lafayette and Lafayette. He moved to Arizona five years ago. He was a member of the American College of Surgeons.

Robert J. Warren, M.D.

Dr. Warren, 61, director of medical education at Reid Hospital in Richmond, died Dec. 10, 1993, at his home.

He was a 1958 graduate of the Indiana University School of Medicine and an Army veteran.

Dr. Warren founded the Pediatric Center and had been director of medical education at Reid since 1986. Before coming to Richmond, he was an epidemiologist at the Centers for Disease Control. He was involved in several community activities, including being a cast member of an upcoming play to benefit the Big Brothers-Big Sisters program. He was a member of the ISMA Key Contact Program. □

Dr. Rex Ragsdale, vice president of medical affairs at Deaconess Hospital in Evansville, has been appointed to the Voluntary Hospitals of America National Physician Leadership Council. The six-member council directs clinical activities for VHA.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke at the Open Structure Rhinoplasty meeting, sponsored by the American Academy of Facial Plastic Surgery in New Orleans; his topics were "Mentoplasty Utilizing Mersilene Mesh," "The Non-Caucasian Nose" and "Alar Onlay Grafting for the Twisted Tip." He spoke on malar, submalar and maxillary augmentation at a facial plastic surgery seminar at University Place Conference Center in Indianapolis.

Dr. Hill Hastings II of the Indiana Hand Center in Indianapolis was course co-chairman for the AO/ASIF International Hand Course in Davos, Switzerland; he spoke on "Bone Loss and Grafting" and "Problems with Intra-articular Fractures" and was a faculty member for laboratory sessions on "Condylar Plate," "T-Plate" and "Bone Grafts." Dr. Hastings was co-author of a chapter on "Dynamic External Fixation for Fractures of the Proximal Interphalangeal Joint" that appeared in the November 1993 issue of *Hand Clinics* and also was co-author of a paper on "Scapholunate Diastasis in Fractures of the Distal Radius: Pathomechanics and Treatment Options" in the December issue of the British edition of *The Journal of Hand Surgery*.

Dr. Christopher D. Prevel, a plastic surgeon at the Indiana University Medical Center, presented a paper on "The Biome-

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

November 1993

Ambrose, Thomas A., Indianapolis
 Bao, Danny C., Carmel
 Burney, Bryan T., Indianapolis
 Chernish, Stanley M., Indianapolis
 Cravens, Eileen E., Richmond
 Harper, Michael E., Tipton
 Heck, Larry L., Indianapolis
 Jones, Thomas A., Indianapolis
 King, Charles R., Anderson
 Lindgren, Ivan T., Aurora
 Lucas, John T., Fort Wayne
 McGarvey, William K., Indianapolis
 Moss, Michael M., Vincennes
 Mullican, William S., Evansville
 Peters, James L., Shelbyville
 Rothbaum, Donald A., Indianapolis
 Sankey, Peggy L., Rockville
 Shelton, Steven R., Jeffersonville
 Smith, John P., Bluffton
 Sneary, Max E., Avilla
 Somes, Claudia J., Indianapolis
 Spellmeyer, John C., Richmond
 Tharp, John D., Muncie
 Trachtenberg, Lee H., Munster
 Warner, T. Max, Greenwood
 Weiss, Robert M., Floyd's Knobs

December 1993

Baker, Sammie B., Evansville
 Bevers, Jonathan H., Columbus
 DeWester, Jeffrey N., Indianapolis
 Dick, Andrew D., Indianapolis
 Dragoo, John R., Wabash
 Engel, Edgar L., Evansville
 Halum, Ramon G., Munster
 Howard, Mary J., Indianapolis
 Kovacich, Michael, Merrillville
 Nora, Paul D., Harlan
 Pancner, Ronald J., Fort Wayne
 Penkava, Robert R., Evansville
 Pratt, G. Byington, Zionsville
 Pritz, Michael B., Indianapolis
 Roggenkamp, Milton W., West Lafayette
 Rust, Robert J., Granger
 Schmidt, Martin, Terre Haute
 Shah, Priyamvada N., Fort Wayne
 Shinn, Gloria L., Keystone
 Skiles, Melvin J., Madison
 Stautz, Curtis C., Newburgh
 Stewart, L. Ray, Evansville
 Stonger, Tristan V., Peru
 Wehr, Gerald W., West Lafayette
 Whitehead, Daniel W., Evansville
 Wigutow, Marcus, Merrillville
 Wolf, Harry C., Indianapolis
 Zeiger, John E., Fort Wayne

chanical Stability of Three-Dimensional Fixation in Hand Fractures" at the annual meeting of the American Association for Hand Surgery. He directed a panel on the treatment of hand and lower extremity trauma at the national meeting of the American Academy of Pediatrics, Section of Emergency Medicine/Plastic Surgery; he also spoke on "Functional Anatomy of the Up-

per Extremity" and "Treatment of Hand Fractures."

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was a faculty member of the second annual winter symposium on the latest advances in facial plastic surgery, held in Aspen, Colo., and sponsored by the Educational and Research Foundation for the American Academy of Facial Plastic and

Reconstructive Surgery; he made presentations on "Practical Uses and Tips for Dermabrasion" and "Study on Complications of Chemical Peel." Dr. Perkins also spoke at a meeting of the Greater Washington, D.C., ENT Society.

Dr. Daria Schooler, a Columbus neurosurgeon, has been appointed clinical assistant professor of neurosurgery at the Indiana University School of Medicine.

Dr. Brent R. McIntosh of Southside Orthopaedic Surgery in Indianapolis has earned board certification in orthopaedic surgery.

Dr. Philip N. Eskew has been appointed director of the obstetrics and gynecology residency training program at St. Vincent Hospital in Indianapolis.

Dr. Steven F. Isenberg, an Indianapolis otolaryngologist, is the author of an article that has been accepted for publication in *Otolaryngology - Head and Neck Surgery*; the title of the article is "Management of Massive Hemorrhage During Endoscopic Sinus Surgery."

Dr. William R. Vaughn, a Vincennes urologist, gave a program on "Urinary Incontinence and the Elderly" at Vincennes University.

Dr. Roger Robison, a Vincennes radiation oncologist, received a three-year appointment as cancer liaison physician for the hospital cancer program at Good Samaritan Hospital in Vincennes.

Dr. Robert E. Pennington, a Richmond surgeon, received a three-year appointment as cancer liaison physician for the hospital cancer program at Reid Hospital in Richmond.

Dr. P. Daniel Read, a Danville surgeon, and **Dr. Thomas S. Whiteman**, a Muncie

otolaryngologist, were named fellows of the American College of Surgeons.

Dr. Richard N. Rubinstein, a Merrillville psychiatrist, was elected president-elect of the Indiana Division of the American Cancer Society.

Dr. Jay Matchett, a Muncie orthopaedic surgeon, has been named to the Ball Memorial Hospital board of directors.

Dr. Edward W. Boyts, a medical review officer at Goshen General Hospital, has been board-certified as a medical review officer.

Arnett Clinic in Lafayette recently recognized the following physicians for more than 30 years of service: **Dr. Robert C. Bolin**, internal medicine; **Dr. Robert E. Hannemann**, pediatrics; **Dr. Fred M. Kuipers**, cardiovascular diseases; **Dr. Richard C. McPherson**, general surgery; and **Dr. Wendell A. Riggs**, pediatrics.

Dr. Bradford Barrett is a new associate of General Surgeons in Richmond.

Dr. Arnold (Larry) Carter of Muncie received the National Multiple Sclerosis Society's 1993 achievement award. Dr. Carter, who was diagnosed with the condition in 1974, is associate director of the Ball Memorial Hospital family practice residency program.

Dr. Philip D. Watson, **Dr. Philip V. Bacidore** and **Dr. David L. Blemker**, Vincennes cardiologists, were named fellows of the American College of Cardiology.

Dr. W. George Brueggemann, a Columbus ophthalmologist, was named a member of the city's Healthy Community Council. **Dr. Sherm Franz**, vice president of medical affairs at Columbus Regional Hospital, is a non-voting

member of the council.

Dr. Joel W. Salon, a Fort Wayne internist, received the Chapter Laureate award of the Indiana Chapter of the American College of Physicians in recognition of exemplary career achievement.

Dr. David E. Wilmot, a Brownsburg family physician, was promoted to major in the Indiana Army National Guard.

Dr. George W. Willison, an Evansville internist, has retired after 55 years in practice.

Dr. Harold G. Hebard has been named medical director of the Indiana Veterans' Home in West Lafayette.

Dr. Boguslaw Uchman, an Anderson pathologist, has been board-certified in hematology.

Dr. Matthew Farber, a Fort Wayne ophthalmologist, spent a week in Albania providing training and lectures in ophthalmology to physicians in Tirana. His trip was organized by Orbis International, a humanitarian organization that fights blindness and eye disease through medical education. He also treated patients at a local diabetes clinic.

Dr. Elizabeth Mann, a Richmond pediatrician, received the Paul S. Rhoads, M.D., Humanity in Medicine Award from Reid Hospital.

Dr. Robert M. LaSalle, a Wabash family practice physician, was honored by the Wabash Project HOPE (Hospital Oncology Program Extended), a project to help cancer patients and survivors; he helped establish the program 10 years ago. **Dr. William Dugan**, an Indianapolis oncologist involved with the program, was also honored.

Dr. John Parker of Goodland has retired after serving the com-

munity since 1957.

Dr. Robert S. Kepner of Student Health Services at Indiana University in Bloomington received a special recognition award from St. John's Children's Clinic in Anderson. He had been a pediatrician in Anderson for more than 30 years.

New ISMA members

Elton Amos, M.D., Fort Wayne, family practice.

H.M. Bacchus Jr., M.D., Fort Wayne, family practice.

Larry W. Banyash, M.D., Fort Wayne, orthopaedic surgery.

Carlos R. Berrios, M.D., Indianapolis, orthopaedic surgery.

Larry Bledsoe, M.D., Fort Wayne, internal medicine.

Wichest Boonyapredeedee, M.D., Munster, pediatrics.

George S. Bowen, M.D., Danville, orthopaedic surgery.

Joel G. Brasch, M.D., Chicago, obstetrics and gynecology.

Kevin E. Burton, M.D., Anderson, radiology.

Frederick T. Chaykowski, M.D., Fort Wayne, orthopaedic surgery.

Jerald L. Cooper, M.D., Fort Wayne, orthopaedic surgery.

John D. Crase, M.D., New Albany, family practice.

Krishna DasGupta, M.D., Fort Wayne, psychiatry.

Mark W. Del Bello, M.D.,

Fort Wayne, nephrology.

Avtar S. Dhindsa, M.D., Valparaiso, urological surgery.

Robert S. Donathan, M.D., Clay City, family practice.

Wallace W. Duncan, M.D., Jasper, family practice.

Jon P. Finley, M.D., Fort Wayne, emergency medicine.

Margaret Frazer, M.D., Indianapolis, neurology.

Daniel M. Gelfman, M.D., Anderson, cardiovascular diseases.

Edmund Gomez, M.D., Indianapolis, obstetrics and gynecology.

Joel A. Hackett Jr., M.D., Indianapolis, family practice.

Victoria R. Heinen, M.D., Indianapolis, family practice.

Samuel R. Heiser, M.D., Noblesville, general surgery.

B. Matthew Hicks, M.D., Fort Wayne, orthopaedic surgery.

Anne T. Hollingsworth, D.O., Michigan City, internal medicine.

Bruce A. Hook, M.D., Fort Wayne, cardiovascular surgery.

David B. Janizek, M.D., Fort Wayne, diagnostic radiology.

Fred K. Lamb, M.D., Terre Haute, psychiatry.

Marilyn M. Mahan, M.D., New Albany, obstetrics and gynecology.

Craig T. Marks, M.D., Fort Wayne, general surgery.

Gregg S. Pollander, M.D.,

Fort Wayne, emergency medicine.

Michael J. Pyle, M.D., Danville, general surgery.

Kevin A. Rahn, M.D., Fort Wayne, orthopaedic surgery.

Subhash K. Reddy, M.D., Fort Wayne, cardiovascular diseases.

Neil M. Richman, M.D., Fort Wayne, orthopaedic surgery.

Gary D. Rusk, M.D., Indianapolis, neurology.

Charles K. Safley, M.D., New Albany, orthopaedic surgery.

Deepak B. Shah, M.D., Fort Wayne, cardiovascular diseases.

Robert M. Shugart, M.D., Fort Wayne, orthopaedic surgery.

Franklin L. Smith, M.D., Fort Wayne, urological surgery.

Garry L. Smith, M.D., Michigan City, general surgery.

Buckley J. terPenning, M.D., Indianapolis, radiology.

Morgan E. Tharp, M.D., Indianapolis, radiation oncology.

Clifton P. Titcomb Jr., M.D., Fort Wayne, internal medicine.

Venkatachala N. Vitalpur, M.D., Fort Wayne, internal medicine.

Jeffrey D. Wagner, M.D., Indianapolis, plastic surgery.

George T. Wallender, M.D., Fort Wayne, internal medicine.

Stanley D. Wissman, M.D., Fort Wayne, neurology.

Joseph W. Yedlicka Jr., M.D., Indianapolis, diagnostic radiology. □

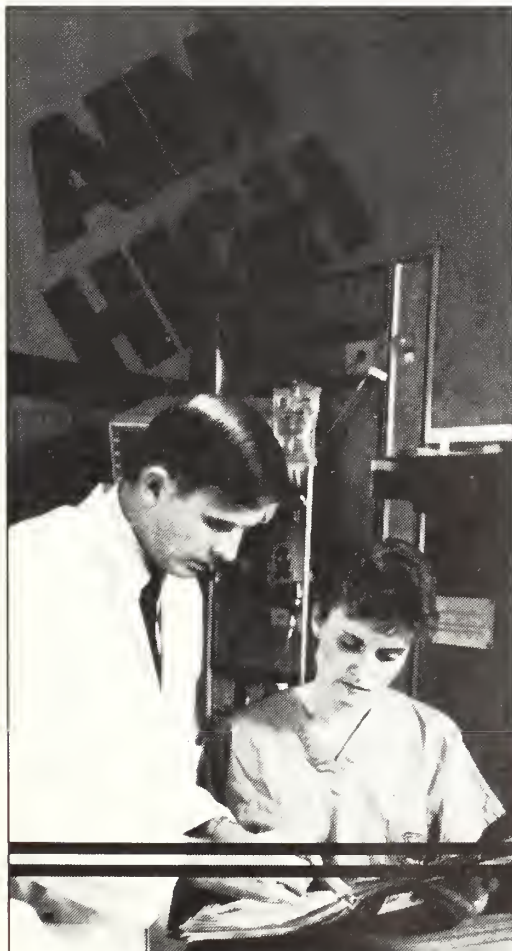
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CompHealth	169
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ISMA Insurance Agency	107, 139, Cover
Indiana University Medical Center	163
James Cancer Hospital	120, 121
Medical Protective	115
Palisades Pharmaceuticals	106
Physicians' Directory	146
Physicians Insurance Co. of Indiana	Cover
Practice Management for Professionals	169
Rehabilitation Hospital of Indiana	109
Shore, M.E., CPA	113
21st Century Software	177
U.S. Air Force	177

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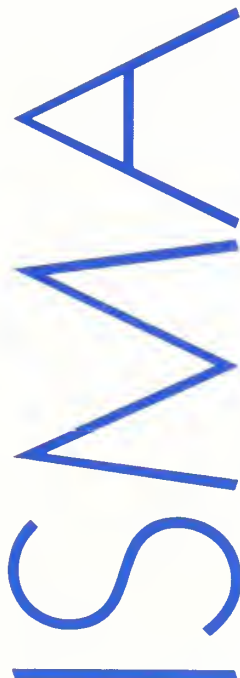
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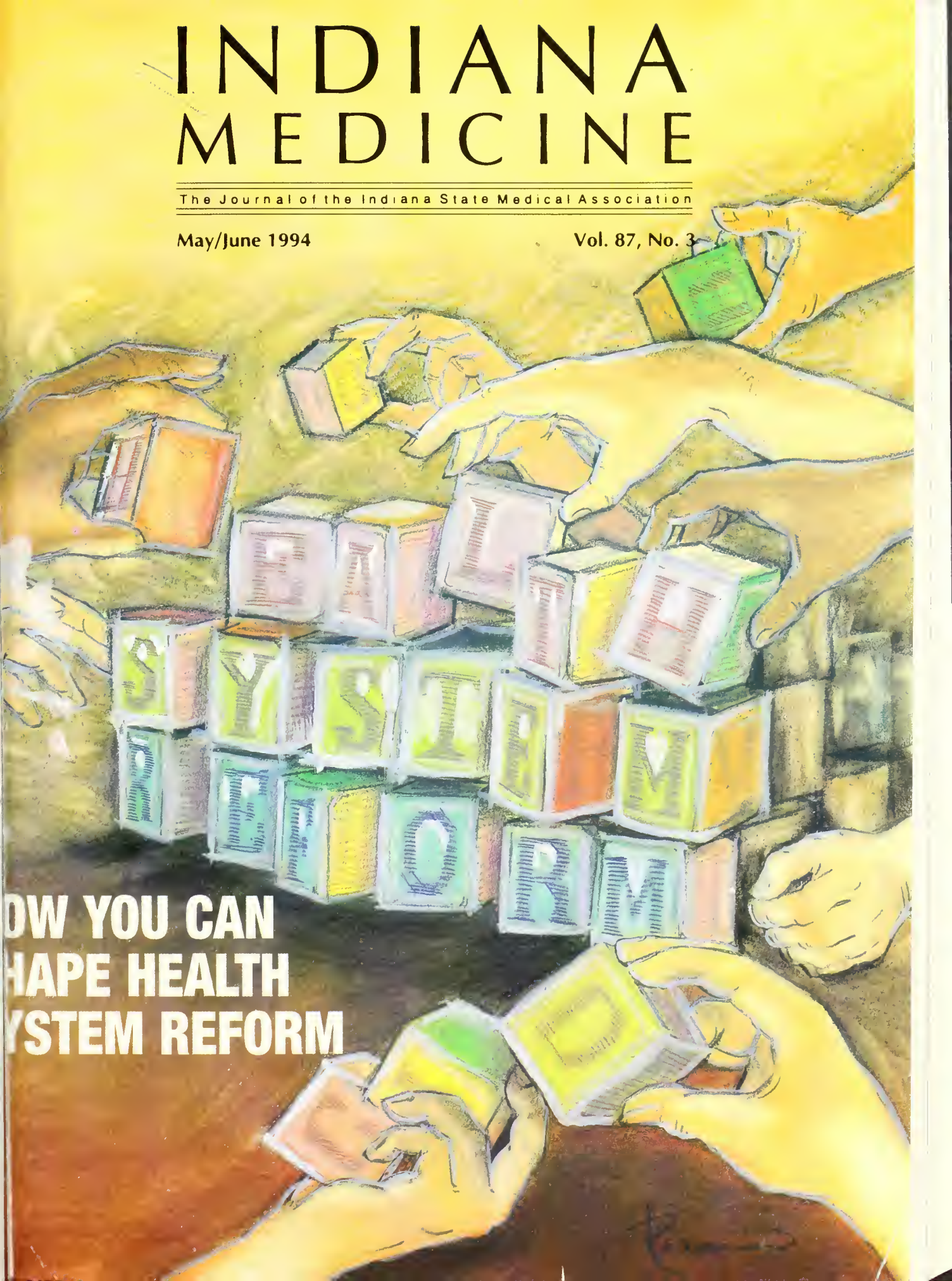
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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

May/June 1994

Vol. 87, No. 3

An artistic illustration in a sketchy, colored-pencil style. It depicts several hands of different skin tones (yellow, orange, brown) interacting with a collection of colorful blocks. The blocks are arranged in a way that suggests they are being built into a structure. Some blocks have letters on them, including 'S', 'Y', 'S', 'T', 'E', 'M', 'R', 'E', 'F', 'O', 'R', 'M'. The background is a warm, textured yellow-orange. The overall theme is about building or shaping a system.

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The Journal of the Indiana State Medical Association

May/June 1994

Vol. 87, No. 3

features

Practice parameters improve patient care 188
INDIANA MEDICINE interviews John Kelly, M.D., director of the AMA Office of Quality Assurance and Medical Review and an expert on practice parameters.

Members can help ISMA shape health reform 196
If the ISMA is to be successful in its health system reform efforts, members must take an active role in shaping the plan. The ISMA is working on several fronts, but it needs the grassroots involvement of physicians to achieve its goals.

Grassroots efforts result in legislative victories 200
The 1994 Indiana General Assembly passed several new laws that will affect the practice of medicine.

Strategic planning: Proactively shaping your future 202
Planning has become an ever increasing critical process to assist medical practices in dealing with the issues of tomorrow.

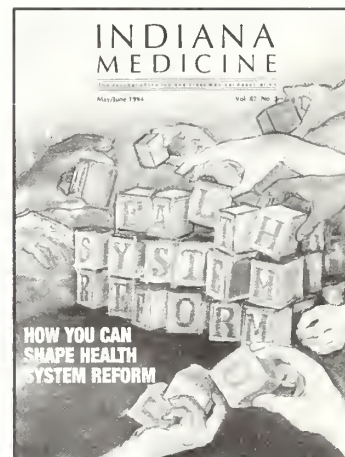
Oral paging in a community hospital: Is it used effectively? 208
A study at Ball Memorial Hospital in Muncie showed that only 7% of its oral pages were emergent.

Are you covered in the event of loss? 212
Life, disability and homeowners insurance can help physicians prepare for the unexpected.

Physical fitness suits doctor to a 'tee' 214
Meet an Indianapolis physician who could have been a professional golfer. She's still a champion on the fairways but also keeps fit by running, playing tennis and mountain trekking.

scientific contributions

Hantavirus pulmonary syndrome in Indiana 216
Improved results with resection of extensive thoracoabdominal aneurysms 220



Cover story begins on page 196. Cover by Lisa Rivard, a freelance illustrator in Indianapolis.

departments

stethoscope 184
guest editorial 186
isma membership report 223
alliance report 242
from the museum 244
cme calendar 246
news briefs 248
isma leadership 250
obituaries 252
people 254
classifieds 258

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

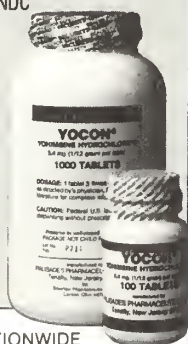
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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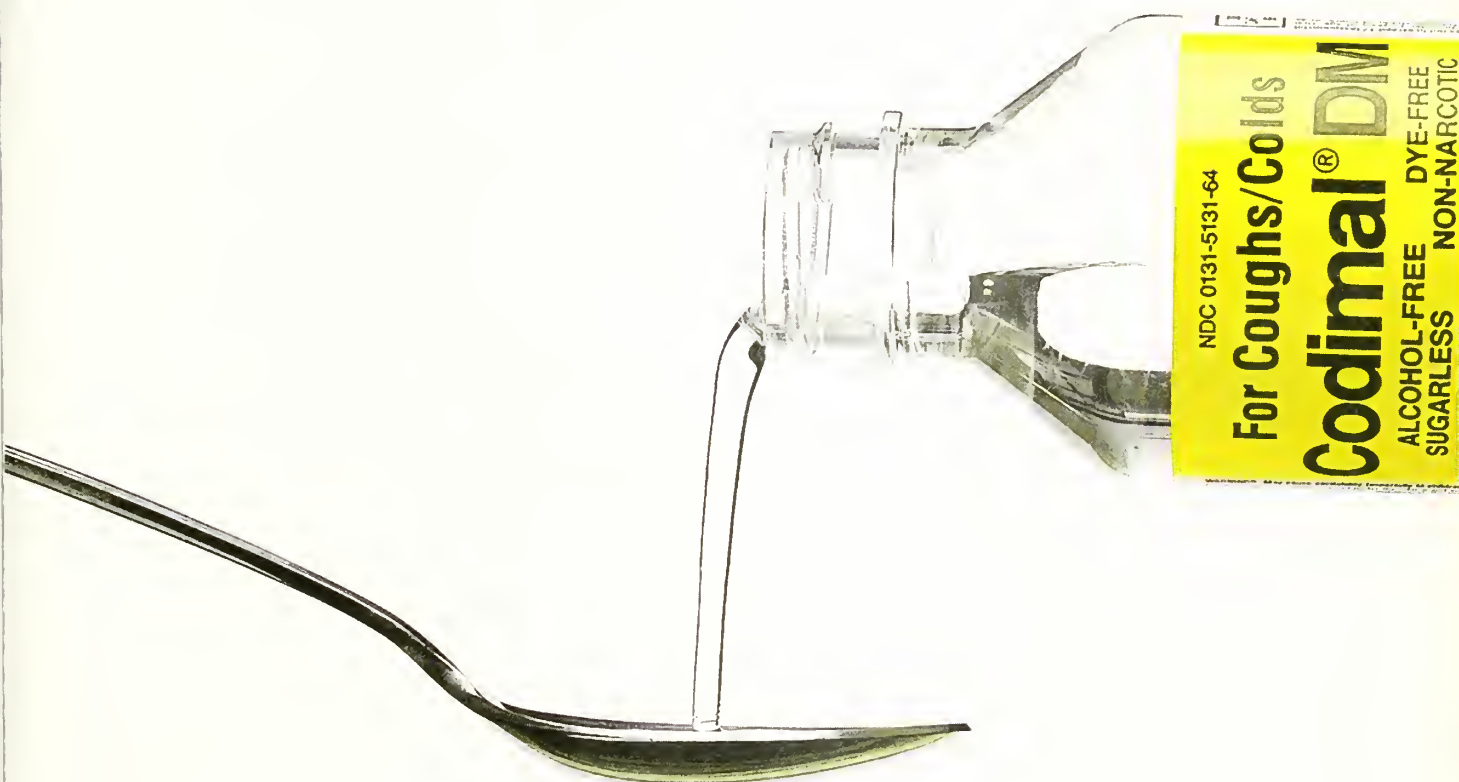
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Medicaid to begin managed care programs

Medicaid will begin implementing a managed care program this summer that will be phased in over a two-year period. The program will have two components, primary care case management (PCCM) and risk-based managed care (RBMC). PCCM will begin July 1, and RBMC will begin Sept. 1.

The two programs are similar, but the state will run PCCM, while RBMC will be administered by private organizations. One or two managed care organizations will be chosen to administer RBMC in each region of the state – north, central and south. The programs were developed in an attempt to find the most cost-effective and efficient way to deliver health care.

During the Medicaid enrollment process, recipients will receive a list of providers from which they will choose a primary medical provider (PMP). After choosing a PMP, the patient will be enrolled in the program the PMP has chosen; the patient will not choose between PCCM and RBMC. Physicians interested in PCCM enrollment should call the EDS Provider Assistance Dept. at (317) 488-1412 or 1-800-346-3819.

ISMA needs members to participate in Medicaid litigation

The ISMA is considering a lawsuit against the state of Indiana to obtain relief from the recently implemented Medicaid Physician Reimbursement Rules. To improve the chances for obtaining relief from the rules, the ISMA needs members who are willing to participate in the litigation. The ISMA is looking for members who:

- believe the rules will have a direct impact on the quality of care or access to medical care available to their Medicaid patients;
- are willing to sign an affidavit;
- will give a deposition; and
- will testify in court regarding the new rules and their impact.

Interested physicians should call Ron Dyer, ISMA legal counsel, at (317) 261-2060 or 1-800-257-4762 or Kevin Speer at Hall, Render, Killian, Heath and Lyman at (317) 633-4884.

ISMA offers seminars on practice management issues

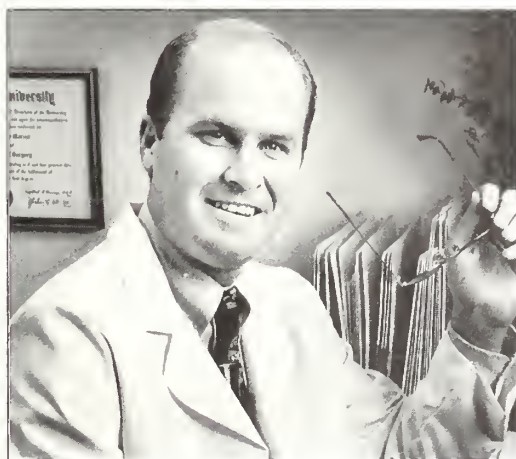
The ISMA has announced its schedule of 1994 workshops for physicians and their office staffs.

Remaining seminar topics include: CPT-4/ICD-9-CM Coding, basic and intermediate; New Business Relationships for the Physician; Personal Planning for the Physician; Stress Management; General Practice Management Issues; The Physician as Employer; E/M Coding Guidelines & Medical Policy Review; Specialty Coding Rap Sessions; Fraud and Abuse, Medical Policy, Documentation, Legal Issues; and 1995 Medicare Updates.

To receive a brochure and registration form, call the ISMA at (317) 261-2060 or 1-800-257-4762. □

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Dedicated defense team strengthens liability protection

Kevin Charles Murray
Indianapolis

When physicians grew increasingly frustrated about the long delays between the date of a proposed malpractice complaint filing and the date the case was closed, the Physicians Insurance Company of Indiana (PICI) and the ISMA knew they had to take action. The result was the dedicated defense team.

Physicians had a right to be unhappy. When the Indiana Compensation Act for Patients (INCAP) was enacted in 1975, everyone involved anticipated that the medical review panel process would be completed within a 12- to 18-month period. Instead by 1992, claims were

pending approximately 33 months from the date of the filing of the proposed complaint to the date the medical review panel opinion was rendered. At the same time, the frequency of payouts in settlement and the amount of payments in settlement were also increasing. Thus, even though Indiana physicians strongly supported INCAP, they were frustrated.

PICI and the ISMA established the dedicated defense team concept to help reduce those frustrations. The team has the following mission statement: To aggressively defend Indiana's physicians, with dedicated professionals who are committed to a coordinated multi-faceted effort to assure just, fair and expeditious resolution of all medical malpractice claims.

As a result, PICI assigns each new file to a special team of lawyers and legal assistants whose sole job it is to aggressively defend your interests.

From September 1992 through December 1993, the team handled 402 cases. During that period, 93 cases were closed.

PICI's dedicated defense team proved that its aggressive efforts paid off. Cases originally assigned to the dedicated team were pending an average of 205 days before closure. This compares to an average of 998 days for cases handled by all other PICI lawyers and 443 days for dedicated team cases that included those that were transferred from other counsel (Figure 1).

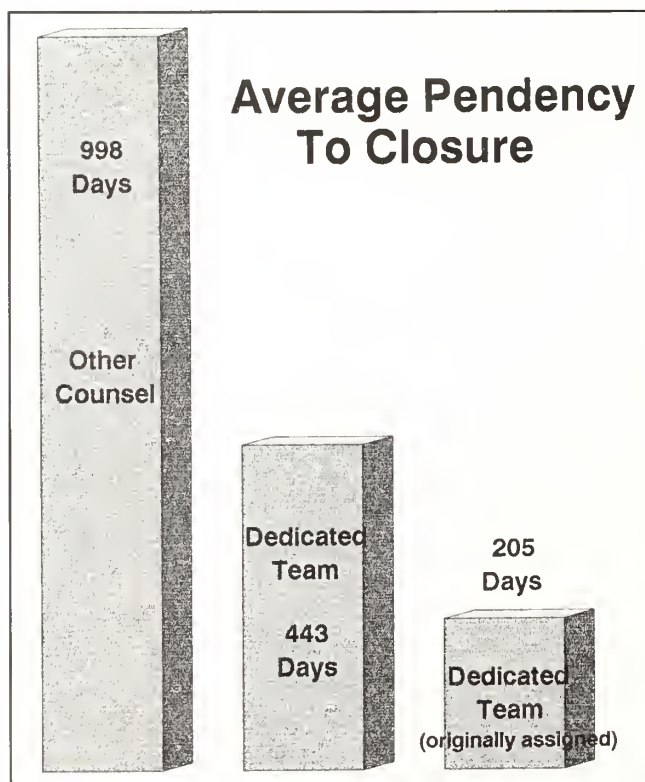
Although many of the dedicated team files have not yet fully matured, there is a significant difference in the percentage of cases closed with payment between PICI's counsel in general and the dedicated team. The payment rate is 2% for the dedicated team and 20% for all other PICI lawyers (Figure 2).

The average settlement payment for the team also was lower than for PICI's other counsel – \$27,500 vs. \$39,627 (Figure 3).

The dedicated defense team is proud of its many innovative approaches. We have developed strategies to expedite the formation of the medical review panel and to prompt plaintiffs to promptly respond to discovery. Since the program began, we have successfully counterfiled actions against plaintiffs and their attorneys for dismissals, and we have recovered attorneys' fees and costs as sanctions.

As another example of our innovative approach, PICI's dedicated team is raising a plaintiff's

Figure 1



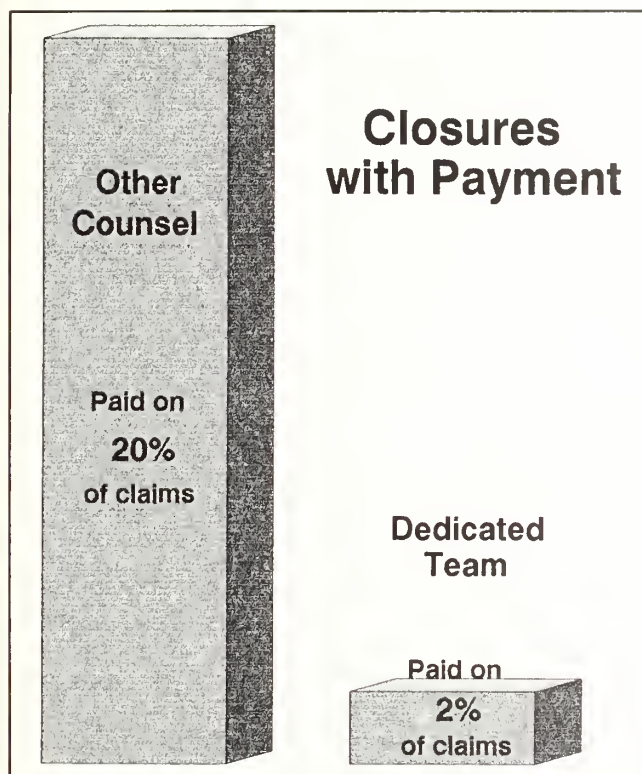


Figure 2

bankruptcy as a defense in medical malpractice matters. The team found that plaintiffs were discharging their debts in bankruptcy, while not listing as an asset of their bankruptcy estate a medical malpractice cause of action against a physician. This was being done in violation of both federal and state laws. Many of the cases disposed of during the 16 months studied were the result of the plaintiffs' failure to comply with bankruptcy laws.

The team approach has been helpful in our effort to develop judge made law, or common law favorable to physicians. For example, the statute of limitations, as the statute is written by the legislature, begins to run on the

date of the alleged act or omission. The judiciary, however, has eroded the statute of limitations by various concepts, such as the doctrine of fraudulent concealment. This doctrine suggests that physicians conceal information from their patients and thus extends the statute of limitations to the date of discovery of the alleged malpractice. Obviously, this severely hampers our defense. We believe this doctrine should not apply unless there is evidence of actual physician fraud. We recently selected an appropriate case to appeal to change this law.

We hope to improve upon other rules of court made law, and we remain alert to proposed legislative changes to INCAP. We

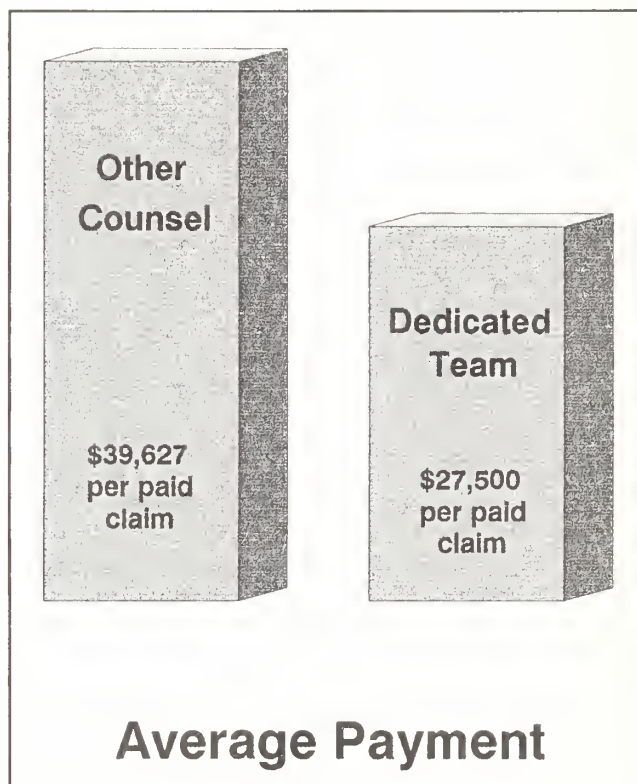


Figure 3

assist PICI and the ISMA in defending the integrity of the medical review panel process before the Indiana General Assembly.

The dedicated team will continue to defend cases aggressively. Most will conclude without payment. When payments are made, I predict that the team's payment will continue to be below average. I also foresee more jury trials and favorable jury verdicts.

I believe that physicians will continue to be pleased with their legal representation in the defense of medical malpractice claims. □

The author is the leader of the PICI Dedicated Defense Team from the Indianapolis law firm of Locke, Reynolds, Boyd & Weisell.

Practice parameters

Bob Carlson
Indianapolis

Depending on whom you talk to, practice parameters can increase the quality of care, help physicians in clinical decision-making, reduce risk, save time, decrease inappropriate care, save money, reduce professional liability premiums and facilitate outcomes research, quality assurance and utilization review activities.

Practice parameters can also make some physicians nervous, especially when they hear about **mandatory** practice guidelines.

One reason for physician concern is that while practice guidelines are being embraced by managed care organizations and finding their way into state and national health care reform legislation, the effects and implications of practice guidelines are only starting to become apparent. How, for example, will guidelines affect professional liability? It may be a while before anyone has a definitive answer for this and many other questions about practice guidelines.

Literally dozens of organizations are developing practice parameters, including local, state and national physician organizations, specialty societies, the federal government and the American Medical Association.

The AMA expert on practice parameters is John Kelly, M.D., director of the AMA Office of Quality Assurance and Medical Review. He coordinates the AMA/Specialty Society Practice Parameters Forum. He serves on committees of the Agency for Health Care Policy and Research, the Institute of Medicine and the Robert Wood Johnson Foundation. Previously, he was the associate medical director at California

Medical Review, the California PRO, and a practicing emergency physician. Dr. Kelly also has served as chairman of the quality assurance committee of the American Medical Peer Review Association and as a consultant to the state of California Health Data Advisory Committee. He received his B.A. at Amherst College, his M.A. and Ph.D. in the history of science at Harvard University and his M.D. from Harvard.

In this phone conversation with *INDIANA MEDICINE*, Dr. Kelly talks about how practice parameters are developed, updated and disseminated and how he sees parameters affecting professional liability and offers practical advice about how physicians can benefit from practice parameters. He begins with some introductory comments about the rationale for developing practice parameters.

Kelly: One of the major challenges physicians currently face is the tremendous amount of information that is currently available. There are thousands of articles published every day in the clinical literature, and there is no way that any physician can keep up with all of that and still have time to care for patients. Practice parameters provide a systematic way to evaluate the scientific literature and to use the experience of practicing physicians in developing useful recommendations to guide clinical practice. The real benefit is to assist practicing physicians in managing particular kinds of clinical issues. Practice parameters are a tool that physicians can use. They are by no means a replacement for clinical judgment. Practicing physicians



improve patient care

can take those recommendations and decide how best to use them in their overall ways of managing patients as well as in the management of individual patients.

There has been a tremendous amount of activity in this area over the last few years. The American Medical Association has been strongly supportive of the effort to develop practice parameters and has played a major role in coordinating the activities of the medical profession in this area. To date, over 60 national physician organizations have developed over 1,600 practice parameters that physicians can use to assist their decision making. At the same time, we also recognize that no matter how good the recommendations developed by national organizations might be, there are both an opportunity and a responsibility for physicians to evaluate the recommendations and see how best to use them. In some cases that may mean they need to modify the recommendations or, for a given patient, to provide care in a way that is different from the recommendations.

What I'd like to do is answer your last question first, which is what is the best practical advice I can give now to physicians about practice parameters. I think physicians should be aware of how useful practice parameters can be to them. Practice parameters provide a highly practical way to obtain useful clinical recommendations on the management of specific clinical conditions. The real benefit of practice parameters to physicians is that they can be a useful foundation for their decision making. Physicians should review the practice parameters that are relevant to their area of

practice and see how best to use them. In many cases, the recommendations will confirm what physicians are already doing. In other instances, the recommendations may be different from the physicians' general way of managing specific clinical conditions, and some modification of practice may be useful. In still other instances, the recommendations in the practice parameters may not be directly relevant to the population for which the physician cares. Our advice would be for the physician to evaluate his or her practice in light of the recommendations, and if they find the recommendations helpful, they should use them.

“

Practice parameters provide a highly practical way to obtain useful clinical recommendations on the management of specific clinical conditions.

”

INDIANA MEDICINE: How are these practice parameters being disseminated to physicians?

Kelly: Probably the best advice that we would offer is that physicians should ask their hospitals, the medical departments of which they're members, the group practices in which they participate or whatever the delivery system of which they're a part, to assist them in assuring that they have access to the relevant practice

parameters. We think the various delivery systems should help assure that physicians have access to the practice parameters that are most relevant to them.

There are a large number of practice parameters. More than 1,600 practice parameters have been developed at the national level, and many more have been developed at the regional or local level, and physicians need to have ready access to those recommendations. Some are published in medical journals. Others are published independently and mailed to members of medical organizations, particularly medical specialty societies. Still others are published independently.

Part of our goal has been to expand awareness about the available practice parameters and to encourage the organizations that develop them to make the information available in as timely a way and as practical a way as possible. One of the concerns we have here is that it's not always easy for physicians to obtain the practice parameters, which is why the AMA has been strongly encouraging the various organizations in which physicians participate to help assure that physicians have access to the practice parameters that are most relevant to them.

Many of these organizations get this information from publications that the AMA distributes. We publish an annual *Directory of Practice Parameters*, which lists all of the available practice parameters. In addition, we update the *Directory* every three months in *Practice Parameters Update* with information regarding new practice parameters, practice parameters that become obsolete and

practice parameters that are under development. Beyond that, each of these publications identifies the specific clinical areas for which practice parameters have been developed, who the sponsoring organization was and where to obtain the specific practice parameters.

The AMA also publishes a large number of current practice parameters on CD-ROM to expand access to the practice parameters. We also update the CD-ROM every three months.

Having good recommendations is an important first step, but the real key to success is getting the recommendations into the hands of practicing physicians.

INDIANA MEDICINE: Many specialty societies and the federal government are involved in developing practice parameters. Who will decide which parameters physicians should actually be using?

Kelly: It's our view that physicians themselves should decide which practice parameters are most useful to them and how best to use individual recommendations. Even if there are multiple practice parameters on a given subject, it's certainly much easier for physicians to review several different sets of recommendations and to decide which ones are most appropriate, than it is to try to review hundreds or even thousands of articles that have been published on a given topic and then to try to sort through the implications of these various articles. It's our view that physicians are best qualified to decide which recommendations are most appropriate to the management of individual patients. That decision

should be made by physicians rather than by government, insurers or other external organizations.

INDIANA MEDICINE: How do you assure that the recommendations are current?

Kelly: One of the major benefits that practice parameters provide is a systematic review of the available literature supplemented by the experience of well-respected clinicians. Once the recommendations are published, there may be

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It's our view that physicians themselves should decide which practice parameters are most useful to them and how best to use individual recommendations.
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new information that becomes available that might necessitate reconsideration of certain recommendations. It's the AMA's view that organizations that develop practice parameters should review their recommendations at least every three years. In fact, we are finding that many organizations are reviewing their recommendations and, when necessary, modifying them, more often than that.

At the same time, physicians themselves bear a responsibility to be aware of new information that becomes available after the publication of specific practice param-

eters that might lead to re-evaluation or modification of specific recommendations. As organizations review their recommendations on a periodic basis, they will decide either to continue to endorse the original practice parameters, they will modify them in certain ways and then publish that information, or replace the practice parameters with new recommendations, and rarely, they will actually withdraw entire recommendations without replacing them. Some of the information the AMA includes in our *Directory* is about specific practice parameters that have been withdrawn or determined to be out of date and about new practice parameters have been issued. It's a dual effort of encouraging organizations to review their practice parameters at least every three years and then publishing that information.

INDIANA MEDICINE: What is being done to encourage physicians to read and use practice parameters?

Kelly: There is very broad support among physician organizations, the AMA, national medical specialty societies and state medical societies. All have played an increasingly active role in facilitating the development of practice parameters, in providing practical information to physicians regarding their benefits and in encouraging physicians to use practice parameters. Articles such as this one are extremely helpful in familiarizing physicians with practice parameters.

I would say that we have made tremendous progress. I think that's evident in the tremendous increase in the number of

good practice parameters that are available, in the number of organizations that are developing the practice parameters and the number of organizations that are encouraging their use. There is also a growing body of published research that has demonstrated the benefits of practice parameters. At the same time, I would say that there is still much more to do in the areas of making the recommendations more practical, more clinically relevant and, most importantly, more accessible to physicians.

One other area where we are seeing a major effort is to try to develop the recommendations in a way that may be useful to patients, so that they have a better understanding of what kinds of questions to ask their physicians and of the recommendations that their physicians provide. There is much to do on the patient education side to help assure that the recommendations are used in the most effective ways possible.

INDIANA MEDICINE: How is the cost of developing and updating practice parameters affecting the cost of the country's health care bill?

Kelly: The primary benefit of practice parameters is to improve the quality of patient care. Our view is that practice parameters will help assure more appropriate utilization of medical care and that this will ultimately facilitate improved value and a better use of health care resources. Currently there are many organizations involved in developing and using practice parameters. Substantial resources have been invested in the development as well as in the dissemination of practice

Attributes of parameters

In its publication titled *Attributes to Guide the Development of Practice Parameters*, the AMA identifies the attributes of a practice parameter as follows:

- Practice parameters should be developed by or in conjunction with physician organizations.
- Reliable methodologies that integrate relevant research findings and appropriate clinical expertise should be used to develop practice parameters.
- Practice parameters should be as comprehensive and specific as possible.
- Practice parameters should be based on current information.
- Practice parameters should be widely disseminated. □

parameters.

But it has been our view that this is an investment that is fully justified because it improves the information available to physicians and helps to guide the utilization of health care services. Our view is that reliable information regarding optimal clinical practice is critical and that the investment in the development and dissemination of practice parameters will help assure the appropriate utilization of health care services. The cost of developing the practice parameters is actually very, very small relative to the overall cost of the services that are currently being provided. And so the real benefit here will be in trying to help identify the best uses of health care resources.

INDIANA MEDICINE: There was initially much hope that practice parameters could save money and improve the quality of care. Are you confident that this is still the case?

Kelly: Well, let me revise the question or at least divide the question. On the quality issue, it's our very strong view that solid information regarding optimal clinical practice is critical to quality patient care. That has been the AMA's goal all along, and we have been pleased with the results. Certainly the number of practice parameters, their usefulness and reliability continue to improve. We are seeing proof of that in various published articles that have shown that practice parameters can be a very useful way of communicating information to physicians and ultimately helping to assure that patients receive appropriate medical services. So the primary benefit of practice parameters has been to improve the quality of patient care, and there continues to be a very solid track record in that area.

An important component of quality patient care is the appropriate utilization of health care services. In some instances, we

find that fewer services are provided. In other instances, more services are provided. The overall consequence is to help assure that health care dollars are well used. It has never been the AMA's view that saving money is the way to evaluate the success of this effort. The real success is measured in terms of improving the quality of patient care and in helping to assure the appropriate utilization of health care services.

INDIANA MEDICINE: Does the delivery of health care services associated with a high implementation of quality practice parameters end up costing more money, make no difference, or actually end up costing less money?

Kelly: It depends on the specific clinical area. We have seen instances in which practice parameters have led to increased costs. For example, a number of practice parameters call for increased use of preventive medical services. That clearly leads to increased costs, but the overall benefit is improved quality of life for the population. We certainly see those resources as well spent. In other instances, the recommendations have led to reduced use of particular services such as cardiac pacemakers. Many patients have been identified who can be managed with other interventions that are less costly. In those instances, there is evidence that resources have been saved. Practice parameters used in anesthesiology have made general anesthesia safer and have led to a reduced number of adverse events. There has also been a decrease of approximately 50% in the professional liability premiums for anesthesiologists.

That's another instance in which there have been real savings that are measurable.

I'll come back to the primary benefit of practice parameters, which is to help assure that physicians have the information they need to make the best decisions for their patients. We are convinced that this is good for quality, that it's also good for utilization and that ultimately it's going to be quality and utilization issues that are going to help determine that the costs for medical care are justified.

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We certainly are concerned that some managed care organizations, to meet business objectives, may limit coverage for services to only the low-cost alternative and might attempt to impose practice parameters in a punitive rather than in an educational way.

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INDIANA MEDICINE: Some managed care networks are already imposing mandatory practice parameters. Do you expect this trend to become more widespread?

Kelly: Many managed care organizations have already seen the potential benefits of practice parameters. What they have done is to help facilitate access to the rec-

ommendations and use them as a way of informing physicians regarding optimal ways to manage specific clinical conditions. We are certainly seeing an expanded use of practice parameters as an educational strategy. In addition, we have also seen practice parameters used as a foundation for various kinds of profiling activities and feedback activities in which physicians are provided with information about their practice in an educational way.

Some managed care organizations have modified specific practice parameters and have attempted to implement requirements that physicians use specific recommendations. Most troubling have been those instances in which managed care organizations use the modified practice parameters with little or no input from physicians whose practices would be affected and in which decisions are based largely on cost rather than quality considerations. We certainly are concerned that some managed care organizations, to meet business objectives, may limit coverage for services to only the low-cost alternative and might attempt to impose practice parameters in a punitive rather than in an educational way.

We do expect expanded use of practice parameters by managed care organizations. The key to their success is going to be active involvement of the physicians whose practice is going to be affected by the practice parameters.

INDIANA MEDICINE: Do you expect practice parameters to be used by the alliances proposed in the Clinton plan?

Kelly: I would change the question to what is the anticipated role of practice parameters in health system reform. If you put it that way, then I would say that many state health reform efforts rely extensively on the use of practice parameters. To date, at least half a dozen states have passed legislation that promotes the use of practice parameters, and we anticipate that many other states will be passing health reform efforts that will promote the use of practice parameters. In addition, a number of the federal reform proposals also promote the use of practice parameters. I think that this governmental interest at the state and the national level in the use of practice parameters is likely to expand and will further encourage the development and use of practice parameters. Perhaps the most detailed recommendations are in [President Clinton's] Health Security Act, which ascribes a very prominent role to practice parameters as a way of addressing quality, utilization and professional liability issues. As health system reform efforts continue to

progress, it's our expectation that practice parameters will continue to occupy a central position in the major reform efforts.

INDIANA MEDICINE: Will physicians be liable if they don't use practice parameters?

Kelly: It's been our view that the availability of practice parameters will not alter physicians' responsibility to provide the best care they can to individual patients and that practice parameters will not increase physicians' current liability risks. In fact, it's our view that in many instances, they might help to reduce physicians' liability risks by providing them with a reliable source of information about how to manage specific clinical conditions. A number of efforts are currently under way to evaluate the potential use of practice parameters to further reduce physicians' professional liability exposure and to provide physicians with a certain level of professional liability protection if they choose to practice in a way that is consistent with specific practice param-

eters. The AMA certainly sees these efforts as promising and encourages further evaluation to see how best to use practice parameters to help address professional liability concerns.

INDIANA MEDICINE: How do practice parameters relate to utilization review?

Kelly: Practice parameters are going to be an increasingly important tool to help guide physicians' decisions about how to manage specific patients. In addition, practice parameters will likely become an important foundation for various quality and utilization review activities. It's our view that the availability of reliable practice parameters will help assure that review is more consistent and fair and ultimately that the decisions are more consistent with a broad consensus regarding optimal ways to manage specific patients. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

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Members can help ISMA shape health reform

Adele Lash
ISMA Director of
Communications

“What is the ISMA doing about ...” the sentence always begins, and lately, it ends with the words “health system reform.” It’s an appropriate question, prompted by members’ concerns that the system under which they have been practicing medicine is a short-lived one. As someone quipped at a recent meeting, “The quo has lost its status.”

Most everyone agrees that change in how health care is delivered is inevitable, but no one knows just how comprehensive the change will be. Will it be free-market based or government-controlled, either through a single-payer system or through the president’s staggeringly complicated plan? Will it be incremental? As the debates go on in Congress and in the media, ISMA’s efforts on health system reform continue on many fronts.

The ISMA plan

The ISMA recognized the need for reform to address imperfections of the health care system – including rising costs and the absence of health insurance coverage for some citizens – and adopted its own health reform package last October after several months of research and discussions. The ISMA’s reform goals fall into four categories: universal access, cost containment, quality and freedom for patients to choose their physician. These four elements must be present in any health system re-

form proposal for ISMA support.

The ISMA plan proposes that to have universal access, a basic benefits package must be made available to all health care consumers. Because such coverage will not be possible without health insurance reform, such shortcomings in our present system as restrictive eligibility criteria, pre-existing condition exclusions, experience rating and lack of insurance portability must be changed.

To curb health care costs, reforms should reduce administrative burdens, attack inefficiencies in the delivery system, address overutilization and eliminate excessive charges and cost shifting. Patients should be informed of the benefits of preventive health and early detection of disease and should assume a role in economic decisions affecting their health.

Cost containment should never sacrifice quality. One possible means the plan suggests to improve quality is through practice parameters – as long as they are properly developed through relevant scientific studies, practical clinical experience and expert opinion.

The ISMA plan would also protect patients’ rights to choose their physician and their hospital and to purchase additional health care services. Physicians’ rights to select the location of their practice and their method of reimbursement also would be preserved.

In adopting a health plan, the ISMA studied many models, but none met the current needs of Hoosiers. However, a modified employer mandate system in the

short term and a consumer choice model in the long term promise to safeguard the ISMA’s health care goals of universal access, cost containment, quality and freedom to choose a doctor. The ISMA plan places the responsibility for health insurance on all segments of society, not just business, for the simple fact that many small businesses in Indiana would be hard pressed to provide insurance coverage to employees. On the other hand, many employees already have insurance through their jobs. The ISMA plan suggests several ways to modify the current employer mandate system over the short term while phasing in a consumer choice model.

Employee premium sharing is an example. The plan proposes to limit the employer’s mandated premium share to less than 100%, while allowing employers to pay a higher share if they wish. Employees would have the option to purchase their own coverage and have the employer make a contribution toward the premium. A system of need-based subsidies would assist employees in paying their premium share for a mandated benefits package.

ISMA’s plan also takes into consideration tax changes that may have to be made. With a consumer choice model, as the ISMA proposes, the tax exclusion for employer-funded coverage would be eliminated, and both individuals and employers would be entitled to the same deduction for health care expenditures. In other words, a health care expenditure would be deductible by whomever made the payment.

Health care IRAs also are included in the ISMA package.

Because so much of the current debate on health system reform is driven by cost, the ISMA contracted with Ted Frech, Ph.D., to do a critical economic analysis of the ISMA plan. When the plan goes "on the road," we want to be certain we can answer all questions that might be raised.

What's next for the ISMA plan?

As the Indiana General Assembly prepared for the 1994 session, the legislative leadership was adamant that no health system reform proposals would be considered during the session. Translating the ISMA plan into legislation for the 1994 session would have been wasted energy when the association's lobbying efforts were needed on the any willing provider issue, among others.

Some might ask why the ISMA at this point in the health system reform debate would even float a health reform proposal. No matter what plan eventually emerges from Congress, states will have a large responsibility in implementing health reforms. The ISMA will have a proposal on the table from which to negotiate along with other players.

Strength in numbers

To strengthen our position, the ISMA has begun coalition development with the Indiana Hospital Association, the Indiana Chamber of Commerce and the American Association of Retired Persons. As consensus develops, a health system reform bill will be drafted for introduction into the 1995 Indiana General Assembly. This process is still in the early stages but has met with enthusiasm.

How to get involved

The ISMA is only as strong as its members are active. There are several ways physicians can influence the health care debate.

Educate yourself about reform

Regardless of plans being discussed in Congress, key elements of any health system reform program must be ensured to **preserve health care coverage, contain costs, maintain quality and protect patients' freedom to choose their own physician.**

Join the speakers bureau

Targeted toward the public, the ISMA speakers bureau provides opportunities to update community groups about health system reform. A speech is provided, along with frequent updates of what's happening in health reform. The public and physicians are allies in the health system reform debate. It's important that this alliance continues to grow. Interested ISMA members should call Janice Herring at (317) 261-2060 or 1-800-257-4762.

Educate your patients

Besides talking to community groups, talk with your patients. Order copies of the brochure "A Message to My Patients" by calling the AMA at 1-800-348-3047, Dept. DPAP. The first 25 copies are free.

Write letters to the editor

Another way to reach the public is through letters to the editor of your local newspaper. Letters should reinforce the key elements that any plan should contain and should be brief and clearly written. Experiences from your own practice can be compelling arguments.

Contact Congress

Be sure your congressional representatives know what you think about health system reform. Meet with them when they are in their home districts. Call or write them, especially when key elements of health system reform are being debated over the next few months. (See the guidelines for writing a letter to Congress.) □

How to communicate with legislators

Elected officials count on constituent input to become effective legislators. Ongoing communication is the only way public representatives will know and understand how you, the voter, feels about particular issues.

As a member of the medical community, your responsibility in communicating with members of Congress is especially great.

The dos

- Clearly identify the subject or subjects, not just House and Senate bill numbers.
- State why you are concerned and use personal experiences.
- Tell how it will affect your patients, the medical profession, your community or family.
- Restrict the letter to one or two subjects.
- Use your own words.
- Communicate while legislation is in committees, subcommittees and on the House and Senate floor.
- Learn the committees and subcommittees on which your Representative and Senators serve.

The don'ts

- Never threaten.
- Never pretend to wield vast political influence.

How to address members of Congress

- Letters should be addressed as follows:

The Honorable John/Jane Doe
United States Senate
Washington, DC 20510

The Honorable John/Jane Doe
House of Representatives
Washington, DC 20510

- The letter should begin with "Dear Senator Doe" or "Dear Representative Doe." □

A white paper and other support materials are being drafted to garner the attention of both the legislators and the media and to inform them of our efforts to preserve quality care for Hoosiers. The information will be distributed to legislators and disseminated to the media through editorial board visits and media interviews throughout this summer. ISMA leaders are preparing now for the media interviews. Media training conducted April 14 and 15 focused on some of the key points the ISMA must make to have an impact on health system reform.

On the national front

We watched this spring as the House Energy and Commerce Committee and the Ways and Means Health Subcommittee each delayed mark-up on the Clinton health reform legislation. Concurrently, groups such as the Business Roundtable, the U.S. Chamber of Commerce, the National Association of Manufacturers and the American Association of Retired Persons failed to endorse the plan. Many ISMA members applauded each setback as one more nail in the Clinton plan coffin. But in the midst of all the naysaying and posturing, compromise movements are afoot in Congress. Portions of any plan currently introduced or any yet-to-be-proposed options could be included in the health system reform proposal that the Congress expects to enact by this fall. So, it is still important for physicians to meet with their U.S. senators and representatives. And that is what the ISMA has done at every opportunity.

Five Congressional offices

sent their health legislative assistants to a Health Care University that the ISMA sponsored in Williamsburg, Va. Among the issues discussed was the need to allow the Indiana Compensation Act for Patients (INCAP) to stand even if other tort reform passes. The ISMA introduced its own health plan to those attending and explained why we support any willing provider laws. "Congressional staffers expressed a great deal of interest in ISMA's Health Plan, INCAP and what impact current legislative proposals would have on Hoosiers," said Michael Mellinger, M.D. An ISMA past president and chairman of the ISMA Task Force on Health System Reform, Dr. Mellinger briefed those in attendance. "The information exchange was an excellent way for the ISMA to present both philosophy and practical consequences of health system reform to those who count."

ISMA President William VanNess, M.D., and past president Michael Mellinger, M.D., attended the AMA's "Partnership" meeting March 7 through 9 in Washington, D.C. Both participated in news media interviews and received updates on the status of various health system reform issues. Other ISMA members scheduled meetings with members of the Indiana Congressional delegation March 9.

"The key is that while health system reform is still fluid, physicians must make their concerns known. Grassroots contact is very important," said Dr. VanNess.

It's not only important for our state and national leaders to hear the physician perspective, Dr.

VanNess believes, but it's important for the public also. Between September 1993 and April 1994, members of the ISMA's speakers bureau made 53 presentations on health system reform to various community groups. Patients want to know how health system reform will affect the way they get medical care. How much will it cost, and will they still be able to make medical decisions with the doctor of their choice? "And they trust doctors to give them the answers," Dr. VanNess said.

A new patient education brochure, "We need a better health care system," is available for ISMA members to distribute to their patients. In clear, concise language, the brochure, produced by the AMA, states that all Americans must be assured of the following: health care coverage regardless of employment, economic status or health condition; choice of physicians and health plans; medical decision making by patients and their physicians; and high quality health care. It urges patients to ask elected officials to support these same goals.

ISMA member education

The ISMA staff and leadership have delivered more than 10 talks to physician and alliance groups and will continue the presentations throughout this year.

Even without legislated health system reform, the health care delivery system continues to change. Physicians must stay abreast of those changes and respond in a manner that meets both their own and their patients' needs. Toward that end, the ISMA has developed a series of workshops on managed care and

other practice management arrangements. Initiated in January with "Decisions for Physician Success in the 90s and Beyond," the workshops will continue throughout the year. Developed by an Indianapolis law firm, Krieg Devault Alexander & Capehart, "New Business Relationships for the Physician," the second in the practice management series, provides practical application of the principles presented in the first seminar. "The Business Side of Medicine" for physicians just beginning practice and "General Practice Management Issues" for all physicians trying to cope with current practice strategies are two other Krieg Devault programs to be offered. They combine with a number of other scheduled programs, including coding, reimbursement, legal issues, Medicare updates, stress management and personal financial planning for physicians.

Still ahead

The ISMA's mission is to protect our members and their patients from threats that will reduce the quality of our current health care system while educating them of the possibilities that exist for improvements in a new delivery system. Neither is an easy task, nor can either one be accomplished without grassroots support of doctors. If you haven't talked to your patients, or spoken to a group in your community, don't put it off any longer. If you haven't written to your congressman or a letter to the editor, it's time. It's easy to say, "What is ISMA doing?" But the ISMA is only as strong as its members. □

Grassroots efforts result in legislative victories

Lou Belch
ISMA Assistant Director of
Government Relations

Many of the 176 bills passed during the 1994 session of the Indiana General Assembly have an impact on the practice of medicine. Of special interest to physicians are new laws on an electronic data transfer system for prescription monitoring, Medicaid anti-hassle, living wills and record duplication fees. Also, thanks largely to grassroots response of ISMA members, the "any willing provider" provision was protected.

When the session convened, legislative leaders had promised that there would not be the contentiousness of the 1993 session. By and large, the leaders were able to keep their promise. The session ended shortly before midnight March 4.

A few of the bills affecting the practice of medicine are summarized below. For more detailed information on all of the bills filed, please consult the *1994 Digest of Health and Medical Laws* available from the ISMA Department of Government Relations.

Electronic data transfer

During the 1993 legislative session, the ISMA was successful in lobbying for the defeat of a bill that would have continued the Multiple Copy Prescription Program.

In working for the defeat of that bill, ISMA was supporting an electronic data transfer (EDT) system of prescription monitoring. The EDT bill was not passed during the 1993 session. The bill did pass the 1994 General Assembly.

The new EDT law allows physicians to write all prescriptions on the same prescription pad and requires pharmacies to transfer, electronically to the state, information regarding prescriptions for Schedule II controlled substances. The patient will also have to present identification to

this new law becomes effective Nov. 1, 1994, Medicaid will have to adjudicate every claim within 30 days. Current law is 45 days. Medicaid is further required to give concise reasons if the claim is not paid.

Living will bill

Changing the living will law has been on the agenda of the legislature for a number of years, but 1994 was the year it finally passed. The new living will law will be effective July 1, 1994, and will allow an individual to make an advance directive in a living will

regarding the provision of artificially supplied nutrition and hydration.

The new living will law will be effective July 1, 1994, and will allow an individual to make an advance directive in a living will regarding the provision of artificially supplied nutrition and hydration.

Charges for record duplication
Effective July 1, 1994, health care providers will be limited in the amount they may

the pharmacist when presenting a prescription. The new law also allows the Board of Pharmacy to define what constitutes a prescription. There is a prohibition on the board's requiring multiple copy prescriptions or requiring different prescriptions for different drugs. There are appropriate safeguards to protect patient confidentiality. This law was effective March 11, 1994, the day it was signed by the governor.

Medicaid anti-hassle

Another ISMA initiative that made it to the governor's desk was the Medicaid anti-hassle bill. When

charge for the duplication of medical records. A provider may collect a charge of 25 cents per page. The provider may also charge a \$15 retrieval charge for "pulling" the record. If a retrieval charge is collected, the provider may not charge for the first 10 pages. The provider is also allowed to charge actual postage costs.

"Any willing provider"

The biggest legislative priority for the ISMA was to protect the "any willing provider" provision of the PPO law. This is the provision that requires PPOs to accept any

physician willing to meet their price. The insurance industry would like to see this provision of the law repealed in order to be able to limit the number of providers in a community.

A bill was filed that basically would have allowed the insurance industry to discriminate against certain providers. The bill was supported by organized labor and the Indiana Manufacturers Association and opposed by many health care providers including chiropractors, optometrists and podiatrists. An amendment was offered to allow the "any willing provider" provision to continue for non-physician health care providers. This left groups

representing physicians as the only interest groups opposing the bill.

Due to an unprecedented grassroots response by ISMA members, the bill was amended to allow the "any willing provider" provisions to stand. The bill does allow PPOs to establish gatekeeper programs, but even those programs must accept any willing provider.

Become involved

The bills listed above are just a few of the many bills that will have an impact on the practice of medicine. The 1995 legislative session is expected to be the health reform session. It is extremely important for physicians to be involved in the

legislative process. Legislators are eager to hear the physician perspective on all issues that affect the health of Hoosiers.

Please consider participating in the ISMA Key Contact Program, which "matches" Key Contact physicians with their legislators. When an issue of importance is being debated at the Statehouse, key contacts are notified and asked to contact their legislators. Remember you are their constituents, and legislators will listen to your opinion.

For more information, please call the ISMA Department of Government Relations, (317) 261-2060 or 1-800-257-4762. □

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Strategic planning: Proactively shaping your future

Michael J. McCaslin, CPA
Whipple & Company P.C.

In today's medical environment, physicians and their practices face new and complex challenges that they have not had to deal with in the past. The emphasis on reducing the cost of health care, increasing access to care, the downward pressure on fees by third-party payers, increased competition among physicians and other alternative providers, and the movement toward strategic alliances are but a few of the factors that have changed the environment in which you practice.

Practicing quality medicine no longer assures your success. The practice of medicine is becoming more of a business, and that

trend will continue if your practice is to survive. Adopting techniques, processes and systems that are used in the business community will become an integral part of your practice.

Planning has become an ever increasing critical process to assist medical practices in dealing with the issues of tomorrow. Changes typically occur much too quickly to survive long-term by only being reactive.

Planning is a proactive process whereby you take control of shaping your future. It is the orderly, systematic review of your organization and the environment in which it exists. It is developing your best projections of how that environment will change, how

external factors affect your environment, and an analysis of internal factors that impact your ability to adapt to change.

In the end, it is identifying goals and objectives for the practice and the physicians, working out a game plan to accomplish those goals and objectives, and insuring that mechanisms are in place for measuring progress.

While these changes are not new to you, their impact is widespread, demanding and knocking at your practice's door each day. You can come out ahead by managing change instead of allowing it to manage you.

Developing a long-term strategic plan will help you look beyond your day-to-day practice operations to consider the future.

Developing a long-term strategic plan will help you look beyond your day-to-day practice operations to consider the future. It is an exercise to clarify exactly what the physicians want as well as a way to qualify conditions such as how, where and when.

A completed strategic plan then provides a management tool to guide the entire organization. Physician groups that go through a planning process significantly increase their ability to survive and prosper in these ever-changing times.

Starting the process

First, all members of your group need to make a commitment to the long-term planning process.

Special emphasis is placed on the word "process." A process is defined as a continuing development involving change and a method of doing something.

Long-term planning is the process of first identifying the needs, problems and aspirations that your practice may experience over the next three to five years. The process continues by shaping these specifications into objectives and goals that you will use to drive your organization.

The process continues further with developing and monitoring projects necessary to attain your goals. Finally, the process revisits the plan periodically to see if any modifications are necessary.

Involve your administrator from the beginning. He or she will probably be directly responsible for

acting on the objectives you establish in your plan and can help coordinate planning sessions.

Next, develop a planning format that best suits the character and nature of your group. Some groups may draft a formal strategic plan with the aid of an outside consultant, while others may prefer an informal weekend session. Remember, the planning process will be more effective if it is kept simple, practical and selective, focusing on key issues.

Establish meeting days and arrange to conduct the planning meetings away from the practice. An off-site location provides a neutral setting for uninterrupted dialogue where physicians can focus on the plan. Provide for call

coverage the day of and night before the planning meeting. You do not want to sit in a day-long planning session having spent the prior night without sleep.

Consider sending out a questionnaire to formally begin the process. It should be designed to be completed quickly and outline the basic issues you are attempting to define. Questions listed should address your practice's health care delivery systems, financial considerations, personnel and group management as they are now and how they are expected to be in the future.

Consider some of these questions:

- How is our group unique?
- What is the overall philosophy that guides the practice?
- What size and type of group are we (number of physicians and their specialties)?
- What programs and services have we added? Should we add?
- Who are our patients – how old, does the practice serve their needs?
- What are the payment systems?
- How have we prepared for managed care?
- What are our specialty's technologies and how do we use them?
- How are we organized internally for decision-making and management?
- Is our office space sufficient? Efficient?
- What is our relationship to our hospitals and other physicians? Are we involved in any joint ventures and with whom?
- Who is our competition and what are their strengths and weaknesses?

- What is our desired image? What are our marketing efforts?

The questionnaire should conclude by having each participant rank the issues in order of priority. Completed questionnaires should be tabulated, summarized and presented at the planning session.

Preparing for the session

The success of the session is directly related to the preparation and participation of each attendee. Therefore, attend the session with an open mind. Be prepared to discuss problems and issues openly and be willing to listen to your partners.

Certain ground rules need to be established up front. Some that should be considered include:

- All participants agree to work together to find solutions with which everyone can live. Decisions are arrived at by consensus.
- Every idea expressed is as valid as any other.
- All participants are on a par in developing ideas and presenting them.
- Every effort should be made to keep sensitive issues on a non-emotional level.
- Maintain a positive approach with a willingness to listen throughout the planning session.
- Maintain a sense of flexibility and an ability to change.

Further prepare by internally analyzing your practice's strengths, weaknesses and capacity. Take a look at your business operations, staff and compensation systems. The questionnaire should prompt you to understand the issues as they currently stand.

It is very important to con-

sider external factors on a national and local level as well. Collect demographic information about the market you serve. Look at your referral sources, payer mix, overhead and other relevant business data.

Establish an agenda indicating the topics to be discussed and the time allocated to each topic. Distribute the agenda to all attendees before the meeting, and stick to it during the session.

Conducting the session

To open the session, review the information summarized from the questionnaire, then brainstorm on the future by developing a list of common themes generated by the responses. For example, a common theme derived from issues relating to adding specialties, acquiring more space and using more advanced technology is bringing on new physicians.

Next, narrow your themes to a list of objectives or things you want to accomplish. Consider each objective in light of three different economic conditions: growth, slow growth and economic decline.

Finally, establish short- and long-term goals and objectives for your practice such as:

- Identify the needs of the practice's patients and how the practice can meet those needs.
- Identify and agree on the changing forces impacting medical practices within the group environment.
- Develop the group's action plan for addressing the goals and objectives stated and the time line for following up on the action plan.

Many of the goals and objectives you develop will be unique

to your practice. It is recommended that you have no more than 10 goals, with four to eight being the norm.

When establishing goals, review each for:

- The action required;
- An estimate of resources required, both human and financial;
- The time frame in which it will be accomplished; and
- The identified outcome, which provides a means for measuring whether the goal is achieved.

Other issues that may arise in your planning sessions are:

- Strategic alliances;
- Managed care capabilities;
- Distribution of income;
- Management of the practice;
- Adding associates;
- Buy-out of partners; and
- Marketing strategies.

These issues are important and impact the long-term direction of the group, but try to avoid the natural tendency to concentrate on immediate problems and issues. Remember to keep a futuristic focus during this session.

At the end of the planning session, you should have a written list of achievable goals. Having

your goals in writing adds weight to their importance and provides something against which to measure progress.

Implementing the plan

The planning process should lead naturally into the implementation of specific projects to accomplish your stated goals.

To begin implementation, divide the plan into projects. Next, decide on the most essential projects and who should do them.

Rank them by evaluating their contribution to the overall objectives.

Determine deadlines and time frames for each project and decide how to measure and evaluate the success of each. Then, schedule the first projects.

Keeping the plan on track

Those responsible for developing a plan must also be responsible for seeing it implemented. Management must communicate its plan to all members of the organization. This requires more than making periodic references to your objectives. It requires a comprehensive plan of communication, in "how to" terms, that reflects your conviction to your

practice's long-term future.

Review projects monthly to see what progress has been made. Repeat the planning process the following year. This may result in a new or revised plan. Modifications to your plan should not be considered setbacks; instead, they should be viewed as refinements to your established, goal-oriented program.

The planning process also provides a framework for developing annual operating plans and budgets. Your annual operating plan should reflect what is expected for the current year, taking into account all projects that must be carried out to support the long-term plan.

The most significant outcome of a long-term planning process is the development of a common vision of the future shared by you, your partners and all members of your practice. Other outcomes are only limited to your commitment. □

Michael J. McCaslin is the officer in charge of Whipple & Company's Medical Group Services Division. Whipple & Company is a 50-person CPA firm located in Indianapolis.

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- **Once-a-day dosing**

- **Low incidence of adverse effects**

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10 mg (loratadine)
TABLETS

* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

Please see following page for brief summary of Prescribing Information.

CLARITIN[®]
brand of loratadine
TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and ocular symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC₀₋₁₂/AUC₀₋₂₄ ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS

Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN

PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg B.I.D. n = 536	TERFENADINE 60 mg B.I.D. n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	3
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported: n 2% or fewer patients.

Autonomic Nervous System: Altered salivation, increased sweating, altered lacrimation, hyposphesia, impotence, thirst, flushing, Body As A Whole: Conjunctivitis, blurred vision, earache, eye pain, linnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.

Cardiovascular System: Hypotension, hypertension, palpitations, syncope, tachycardia.

Central and Peripheral Nervous System: Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System: Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System: Arthralgia, myalgia.

Psychiatric: Anxiety, depression, agitation, insomnia, paranoia, amnesia, impaired concentration, confusion, decreased libido, nervousness.

Reproductive System: Breast pain, menorrhagia, dysmenorrhea, vaginitis.

Respiratory System: Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.

Skin and Appendages: Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.

Urinary System: Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema, abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis, alopecia, seizures, breast enlargement, erythema multiforme, and anaphylaxis.

OVERDOSAGE

Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD₅₀ values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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Oral paging in a community hospital: Is it used effectively?

Cortland Caldemeyer, B.A.
Anthony R. Dowell, M.D.

Every hospital requires an effective communications system that efficiently locates hospital personnel. Urgent messages may be delivered using electronic beepers for selected individuals, and an oral paging system may be used for more universal announcements. The system for urgent messages must function effectively; misuse of the system could lead to delayed responses during emergencies and to impaired patient care. At the very least, inappropriate use of oral paging leads to noisy distractions for hospital personnel and patients.

This study at Ball Memorial

Hospital, Inc. in Muncie was designed to evaluate the number, frequency and quality of oral paging during a five-day period, Monday, July 22, through Friday, July 25, 1991. During that period, the hospital operators recorded all oral page requests between 8 a.m. and 5 p.m. using a specially constructed log-in form. The operators recorded the time and date of the page, whether the page was an emergency (stat or code), whether the person requested to be paged was wearing a beeper, the occupation of the person being paged (e.g., physician, nurse, respiratory therapist) and the number of times a page was requested (multiple pages).

We wanted to know the number of oral pages at Ball

Memorial Hospital during this arbitrary period, who was using the oral paging system and for what purpose. We wanted to know how many oral pages were truly emergent and how many were clinical or directly related to patient care.

Results

During the period from 8 a.m. Monday through 5 p.m. Friday, 312 oral pages were recorded (Table). Physicians accounted for 24% of the pages, followed by utilization review personnel (14%), maintenance personnel (10%), nursing service personnel (9%), physical therapists (7%), laboratory personnel (6%), surgery personnel (5%), biomedical services personnel (5%), housekeeping personnel (4%), respiratory therapists (4%), visitors and patients (3%), and ancillary service personnel (1%). Other hospital departments (laundry, dialysis, radiology, psychiatry) accounted for the remaining 8% of oral pages.

Twenty-three percent of the oral pages were multiple pages; the physicians accounted for only one third of these (Figure 1).

Eleven physicians and six hospital employees were orally paged while they were carrying an electronic beeper, accounting for 5% of the total number of pages.

Approximately two-thirds of the 312 oral pages were clinical or directly related to patient care; many of the remaining pages were indirectly pertaining to patient care (maintenance, housekeeping). Only 22 oral pages (7%) were true emergencies or codes requiring an immediate response from a

Table

Personnel orally paged during the five-day study period, July 1991

Personnel	Number of pages	Percentage
Physician	76	24%
Utilization review	43	14%
Maintenance	30	10%
Nursing service	29	9%
Other hospital dept.	25	8%
Physical therapy	24	8%
Laboratory	19	6%
Surgical services	17	5%
Biomedical services	14	4%
Housekeeping	13	4%
Respiratory therapy	12	4%
Visitor/patient	8	3%
Service	2	1%
Total	312	100%

hospital team.

The frequency of oral paging was evenly distributed throughout the five-day study period (*Figure 2*). More oral pages were recorded during the morning (65%) than during the afternoon (35%) of each study day, with the peak frequency occurring around 9:30 a.m. (*Figure 3*).

Discussion

Effective communication is an important function in a hospital. Communications may be divided into emergency and routine messages. Most non-patient care messages are not emergent; they can be delivered by telephone or written memoranda. The use of the hospital oral paging system should be reserved for emergent announcements or at least urgent patient related messages because of its ability to reach widely throughout the hospital and to be quickly monitored for response. The system should be used to

quickly and efficiently dispatch personnel to deal with a hospital or patient care related crisis. Use other than emergent or urgent reasons is a misuse of the system. Hospitals tend to be noisy places causing adverse psychological and cognitive effects in patients and personnel.¹

Our data show that only 7% of the 312 oral pages during the study period were emergent. Although nearly two-thirds of the remaining oral pages could be classified as patient care related, the remaining one-third were not directly related to patient care and were not emergent or even urgent in nature. Twenty-three percent of the 312 oral pages were repetitious, and physicians accounted for only 32% of these multiple pages. Five percent of the oral pages were for 17 people who were wearing electronic beepers at the time they were paged, and six of these 17 individuals were paged orally for non-emergent reasons.

Similar findings were reported by Katz and Schroeder in their study of electronic beeper paging during a three-day period in three teaching hospitals.² Thirty-one logs from 26 interns were completed; a total of 1,206 pages were recorded on 91 days (1,095 hours). Interns were paged an average of once an hour; on 24 occasions, interns were paged five or more times an hour. Most pages (65%) occurred when interns were engaged in patient care. Only 34% of the pages were judged both to require a response within one hour and to result in a change in patient care. Twenty-four percent were clinically indicated and required a response within one hour but did not result in a change in patient care. Sixteen percent of pages resulted in a change in patient care or were clinically indicated but could have been postponed for more than an hour. An additional 26% of pages neither resulted in a change in clinical management nor

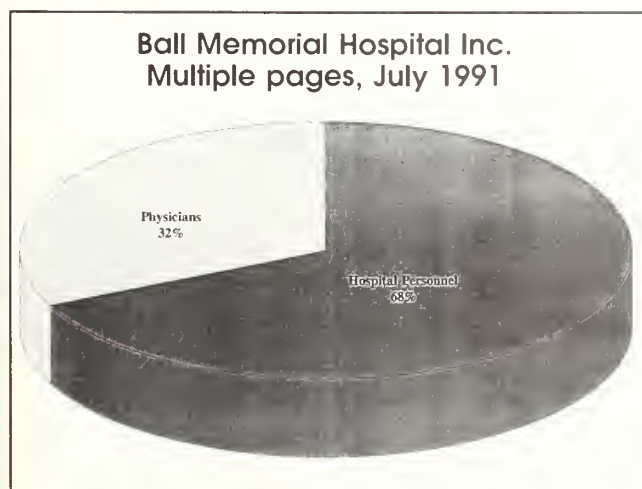


Figure 1

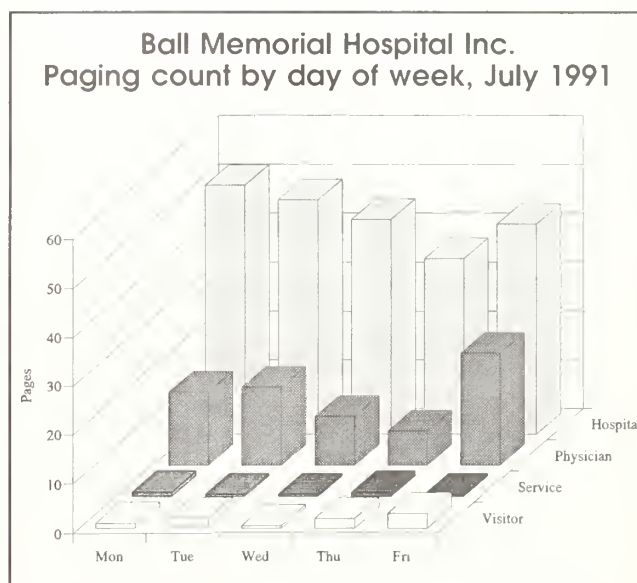


Figure 2

**Ball Memorial Hospital Inc.
Paging count by hour, July 1991**

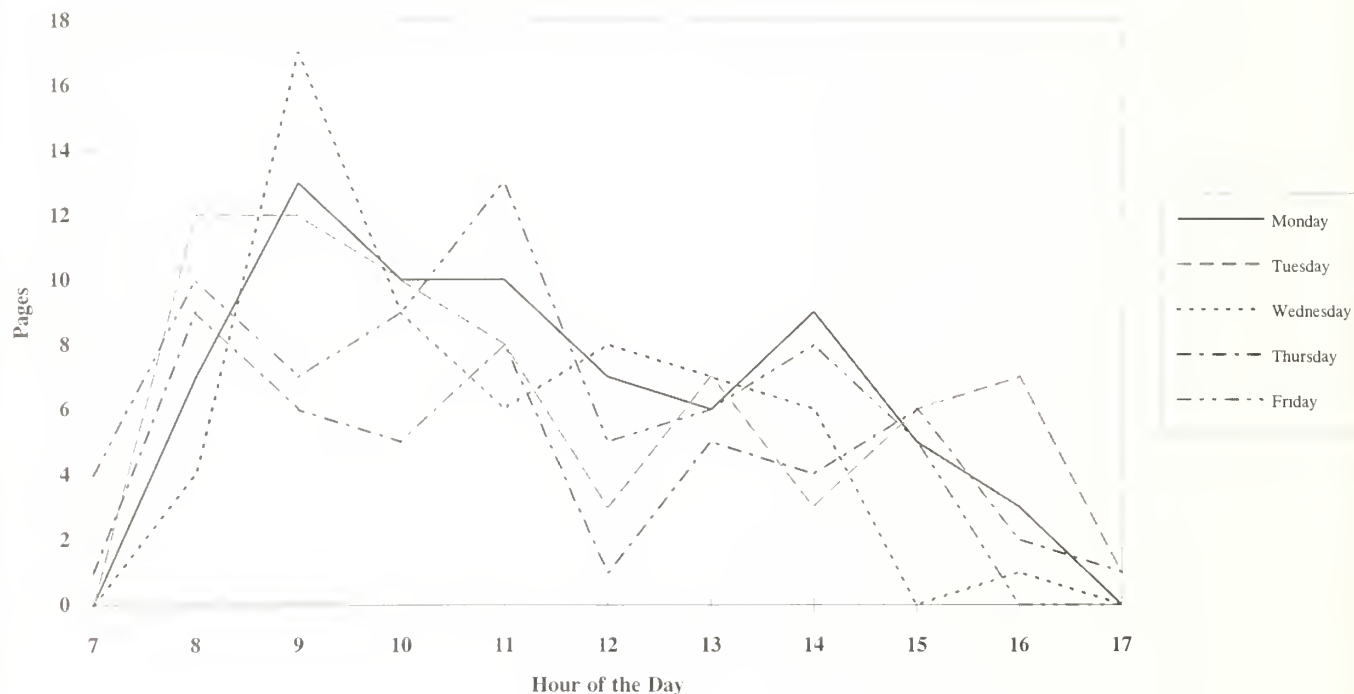


Figure 3

were clinically indicated. Therefore, 42% of the pages were clinically unnecessary and could have been postponed or delivered by other means of communications.

Not only were most oral pages in our study not emergent, but they were distracting and may have delayed pages that were emergent. For example, utilization review personnel alone accounted for almost 50% of the non-direct patient care related oral pages in this study period. We suggest that other means of contacting hospital personnel for non-emergent, non-patient care related activities

should be used (e.g., electronic beepers).

Although the use of hospital paging should be reserved for emergencies and urgent calls related to patient care, it is more important to avoid missing an actual or potentially serious incident (maximal sensitivity) than to avoid unnecessary pages (specificity). Hospitals should be encouraged to monitor the use of their paging systems so that they can improve the efficiency of communications and ensure the best use of their personnel resources through quality management programs. Noise reduction

technology may include the use of vibrating rather than audible pocket-paging systems, greater reliance on visual-only monitor screens and graded alarm systems that generate increasingly louder or faster signals depending upon the urgency of the message. Education programs, such as those suggested by Barton³ that stress improved practices through interservice planning, goal setting and follow-up evaluation, may be implemented for physicians and hospital personnel.

In our hospital, we intend to improve the efficiency of the hospital paging system and reduce

unnecessary oral pages, which should reduce background distractions, provide relief of operator burden and lead to a quieter hospital. □

Caldemeyer is a first-year student in the Indiana University School of Dentistry who did an externship at Ball Memorial Hospital in Muncie in

July 1991. Dr. Dowell is a member of the clinical staff at Ball Memorial Hospital.

Correspondence: Anthony R. Dowell, M.D., Ball Memorial Hospital, 2401 University Ave., Muncie, IN 47303.

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policy only pays for repairs or replacement subject to the policy limit, which may not be adequate to replace your home. The contents of your home also should be insured for their full replacement value.

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A periodic review of your insurance coverage will protect you in the event of a loss. An insurance evaluation also may reveal that you have a policy that's no longer necessary. A thorough review now will ensure that you're properly covered if you need assistance later. ▢

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Physical fitness suits doctor to a 'tee'

Tina Sims
Managing Editor

Polly Nicely, M.D., could have been a professional golfer. But turning pro wasn't the thing to do for a girl from Iowa in the 1960s, so she went to college instead.

Fortunately, her flexible schedule as a part-time physician at the Indiana Women's Prison in Indianapolis still gives her time for her favorite form of recreation. In addition, many of her volunteer activities have allowed her to merge her medical career with her interest in physical fitness.

Dr. Nicely won the championship at Meridian Hills Country Club in Indianapolis 12 times between 1974 and 1993. She has

played there for 26 years and usually gets in about four rounds a week during the summer.

She plays in the women's city and state tournaments and proves to be a strong competitor. She was a semi-finalist in the state tournament the first year she came to Indianapolis and has been runner-up several times in the city tournament.

Her only hole-in-one came at Meridian Hills, her home course, on the 16th hole in 1992. She could almost see it coming. "I hit a good shot," she remembers.

Dr. Nicely grew up playing golf. "When I was a kid, that's all I did," she says. Her parents belonged to a country club, where she took lessons starting at age 12. She excelled at the sport, becoming so good that when the LPGA

tour came to Iowa, she was asked to play. For a girl of 16, the chance to team up with professional golfers Louise Suggs, Patty Berg or Mickey Wright was a dream come true. "For me as a kid, that was the biggest thrill of my life," she says.

Despite her talent, she turned down a golf scholarship. "I didn't think I should do that. It wasn't the thing for women to do," back then in Iowa, she says. "I thought I should go to college."

Golf isn't her only form of exercise. She runs 3 to 5 miles a day five days a week and increases her distance when training for a race. Since 1980 she has run the 13.1-mile "500 Festival" Mini-Marathon in Indianapolis almost every year, usually finishing in about two hours. She also runs on St. Vincent Hospital's team in the annual Corporate Challenge.

She took up running in the late 1970s to get in shape for a mountain trekking expedition. Because running was just starting to become popular, especially for women, she endured taunting, teasing and obscenities from motorists and other passers-by as she jogged. "It wasn't the thing for women to do. People thought you were wacko," she says.

Even away from home, she sticks to her running routine. For the past two years, she has organized a group from her church that travels to Honduras to help build a hospital. Despite the fact that they perform hard labor during their nine-day stays, several in the group, including Dr. Nicely, also fit running or walking into their schedule.

Running helped increase her

Dr. Nicely gets in about four rounds of golf a week. Her favorite golf courses include the three courses at Desert Mountain near Scottsdale, Ariz., and The Dunes course at Sanibel Island, Fla., where she enjoys watching the wildlife.



strength and stamina on two mountain climbing treks. In 1978, she climbed to Camp I, an elevation of 16,500 feet, on Manaslu, the world's seventh highest mountain, with the Colorado Himalayan Expedition. Three years later, she joined the American Medical Research Expedition to Mount Everest, climbing to the base camp, an elevation of 18,000 feet. She hiked about 8 to 10 miles a day during the month-long expeditions.

The biggest surprise of the treks occurred when the travel agent handed her a small bag of medical equipment and maps and informed her that she was the doctor for the Manaslu trekking group. When she wondered what she would do if someone was struck with acute appendicitis miles from civilization, he replied that she should send a runner to request a helicopter rescue. But there were still no guarantees that a helicopter crew would come to their aid, she was told. Fortunately, no serious medical emergencies occurred.

The incident, however, made Dr. Nicely aware of the liability risks she could face as a physician on such trips. She has joined the Wilderness Medical Society, which has its headquarters in Indianapolis and offers courses on such subjects as serving as the physician on wilderness trips.

Because she is so interested in fitness and sports medicine, she has offered her medical services at many athletic events in Indianapolis. She was director of medical coverage for the women's professional tournament tennis tournament from 1983 to 1992, served as a physician at the RCA (formerly GTE) Tennis Champion-

ships from 1977 to 1992, was a member of the executive and steering committees of the White River Park State Games from 1983 to 1987 and was chairman of the Pan American Games Medical Services Advisory Committee from 1985 to 1987. She is among a team of physicians studying and treating some of the best figure skaters in the United States who are training at the Indiana/World Skating Academy in downtown Indianapolis.

Sports medicine has interested Dr. Nicely since its infancy in Indianapolis. She used to give lectures on fitness for women as part of St. Vincent Hospital's wellness program and worked with George Rapp, M.D., at St. Vincent and Thomas Brady, M.D., who started the sports medicine clinic at Methodist Hospital. She is a member of the ISMA Commission on Sports Medicine and the American College of Sports Medicine.

She has received several awards for her work in sports medicine, including The Women's Sports Foundation 1991 Sports Leader Award, and the 1990 Indiana Governor's Council for Physical Fitness and Sports Award. She was named a Sagamore of the Wabash for her work as chairman of the Indiana Governor's Council on Physical Fitness and Sports Medicine from 1983 to 1987.

In addition to golf, running and trekking, she also plays tennis and platform tennis.

As a physician, she feels she should be a good example to her patients. She exercises, eats right and doesn't smoke – and expects patients to do the same. "I don't like to tell people to do anything I'm not willing to do. I have to



Dr. Nicely prepares to tee off at Meridian Hills Country Club.

have done it," she says.

Her two daughters have followed her example. Both play golf, and one daughter is a triathlete.

Dr. Nicely continually sets new goals for herself. She wants to climb Kilimanjaro and Kenya. She hopes to enter the Boston Marathon someday. She would like to get her golf handicap down to a 5 again. She would enjoy playing the Pebble Beach (Calif.) course.

And she would give anything to play at Augusta, Ga., the site of the annual Masters Tournament, but that probably will never happen, she says. "Women can't play there." □

Hantavirus pulmonary syndrome in Indiana

Robin T. Zon, M.D.
Thomas G. Slama, M.D.
Indianapolis

In spring 1993, a new hantavirus respiratory illness, hantavirus pulmonary syndrome (HPS) was recognized in the southwestern United States – Arizona, New Mexico, Colorado and Utah, known as the Four Corners area.¹⁻⁴

The newly recognized strain of hantavirus, the Muerto Canyon strain, is a negative stranded RNA virus belonging to the family Bunyaviridae. The principal reservoir for this unique strain of hantavirus, the deer mouse, *Peromyscus maniculatus*, inhabits most of the United States, except the Southeast.⁵

A confirmed case of HPS is characterized by a prodrome consisting of fever, myalgia and variable respiratory symptoms (e.g., cough), rapidly followed by unexplained adult respiratory distress syndrome (ARDS), bilateral pulmonary interstitial infiltrates with respiratory failure and laboratory evidence, including serology and histopathology, of a recent hantavirus infection.⁶

Through 1993, additional cases of HPS were reported as far east as Minnesota and Louisiana.⁷ In 1994, Indiana reported its first confirmed case of HPS, which we describe in this report.

Case report

A 48-year-old white man with

insulin-dependent diabetes mellitus presented Jan. 8, 1994, with a three-day history of myalgia, weakness, nausea, vomiting, fever, non-productive cough and progressive dyspnea. He had taken acetaminophen with little symptomatic improvement. There were no additional significant past medical problems. To our knowledge, the patient had not traveled to the Southwest and had no known exposure to rodent excreta at the time of admission.

On physical exam, the patient was tachypneic, tachycardiac and generally appeared ill and in moderate distress. His skin was pallid, diaphoretic, without rash or petechiae; there were no signs of meningeal irritation. Auscultation of the lungs revealed shallow respirations with few diffuse rhonchi and rales. The cardiovascular examination, other than tachycardia, was normal.

Initial laboratory studies revealed the following: urinalysis, normal; westergren sedimentation rate, 1 mm/hr; WBC count, 40.5 K/mm³, with 55% segmented neutrophils, 31% band forms, 5% lymphocytes, 7% monocytes, 1% atypical lymphocytes and 1% metamyelocytes; hemoglobin 18.7 gm/dL; platelets, 102 K/mm³; sodium 122 mEq/L; calcium, 5.6 mg/dL; phosphorus, 5.3 mg/dL; LDH, 430 mu/mL; albumin, 1.3 gm/dL; glucose, 518 mg/dL; Ck 21 IU/L MB 2 IU/L, lactic acid, 10.5 mEq/mL; pH 7.54; PaO₂ 38 mm on .50 FIO₂. Blood cultures, Influenza A and B titers,

Legionella urine antigen, Legionella direct fluorescent antibody staining of sputum and serologies, acid-fast stains of sputum, *Histoplasma capsulatum* urine antigen and *Mycoplasma pneumoniae* cold agglutinin titers were non-reactive. EKG was normal. Chest roentgenogram revealed diffuse bilateral interstitial infiltrates.

The patient's respiratory failure required conventional mode ventilatory support, and broad-spectrum antibiotic coverage with cefuroxime and erythromycin was instituted. Fourteen hours after initial presentation, the patient developed refractory hypoxemia with worsening bilateral diffuse infiltrates (Figure), acute renal failure and septic shock syndrome with disseminated intravascular coagulopathy. Despite aggressive ventilatory support, anti-bacterial chemotherapy and the addition of antiviral coverage with amantidine, the patient died 27 hours after presentation.

Autopsy was obtained with gross anatomic findings including large bilateral pleural effusions, 2.0-2.5 liters, and edematous lungs, 1,000 grams each. Histologically, the lung pattern revealed early diffuse alveolar damage classified as exudative stage. Smudging nuclei in the alveolar pneumocyte, suggestive of a viral etiology, were also noted. The spleen histology demonstrated florid follicular hyperplasia of the white pulp with accompanying immunoblastic

proliferation. Scattered plasma cells were noted, but there was no diagnostic evidence of malignancy.

The Centers for Disease Control and Prevention (CDC) confirmed the diagnosis of hantavirus by enzyme-linked immunosorbent assay of the patient's serum and an immunoperoxidase stain for hantavirus antigen on fresh frozen lung tissue.

After the case was confirmed, representatives from the Indiana State Department of Health (ISDH) and the CDC conducted rodent trapping on and around the patient's property and place of employment; 26 rodents were trapped. Four of the 26 rodents tested seropositive for the hantavirus; three were deer mice (*Peromyscus maniculatus*), and one was a meadow vole (*Microtus pennsylvanicus*).

Discussion

Clinical syndromes associated with other strains of hantavirus historically have been characterized by hemorrhagic fever and renal involvement, as first reported in its association with Korean hemorrhagic fever.^{8,9}

No clinical disease related to the hantavirus in humans had been documented in this country until May 1993. Through January 1994, there had been 54 documented cases of HPS, with a 60% mortality rate.¹⁰ The clinical expression of hantavirus infection in the United States is distinguished by the predominance of respiratory symptoms and limited renal involvement.

There is, however, no defined set of symptoms and signs at presentation that can distinguish HPS from other forms of noncardiogenic pulmonary edema. Screening criteria for HPS devel-

oped by the CDC include febrile illness with unexplained ARDS or bilateral interstitial pulmonary infiltrates requiring supplemental oxygen within one week of hospitalization. Additional laboratory patterns include thrombocytopenia, hemoconcentration, leukocytosis, increased band forms on differential, hypoalbuminemia and lactic acidosis.¹¹ Our patient met all these criteria.

Human infection may occur when infective rodent saliva or excreta are inhaled as aerosols produced directly from the animal or when dried materials contaminated by rodent excreta are disturbed, directly introduced into broken skin or onto the conjunctivae or, possibly, ingested in contaminated food or water. Persons have also become infected after rodent bites. Person-to-

person transmission, even by direct contact with blood or body fluids, has not been documented.¹²

Currently no rapid test exists for early diagnosis of hantavirus infection. Therefore clinicians should have a high degree of suspicion when evaluating patients with a similar constellation of clinical parameters and inquire about exposure to rodents.

Supportive measures are the basis of therapy; severe hypoxemia should be avoided and cardiotoxic drugs employed to maintain perfusion without overhydration. Appropriate treatment to cover infections mimicking HPS should be employed early and alternative diagnoses sought. Based on evidence of activity of intravenous ribavirin therapy against hantavirus infection,^{9,13} intravenous ribavirin has been made



Figure: Chest x-ray taken on admission reveals panlobar interstitial infiltrates.

available through a CDC-sponsored open label protocol for patients with suspected HPS. Intravenous ribavirin was used to treat the first Colorado survivor of HPS.^{14,15}

Minimizing contact with rodent saliva and excreta is paramount for avoiding disease. CDC recommendations for residents in endemic areas include preventing rodent infestation, eliminating rodents, reducing availability of food sources and nesting sites used by rodents inside the home and careful disposal of rodent carcasses in bleach and plastic bags. Bagged remains can then be buried or burned.¹²

Suspect cases should be reported to the ISDH Communicable Disease Division. To report suspect cases or obtain information on reporting, diagnosis, laboratory testing and treatment of HPS, call 317-633-8415.

Physicians who want to enroll patients in the CDC protocol should contact the CDC Ribavirin Officer of the Day, (404) 639-1510 weekdays or (404) 639-2888 evenings and weekends. The CDC also provides a recorded message regarding the hantavirus: 1-800-532-9929. ▀

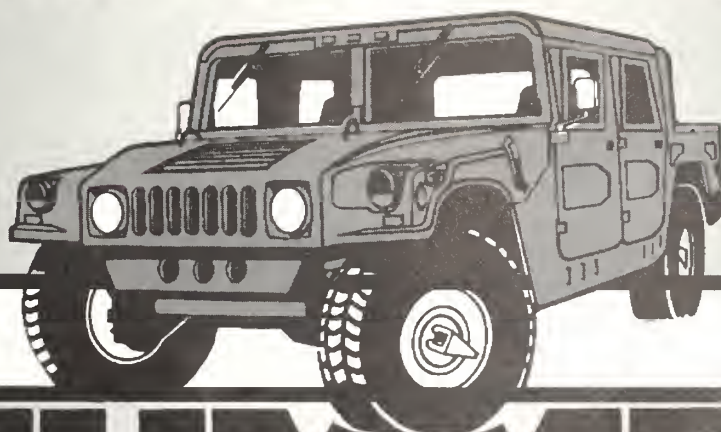
Dr. Zon is a resident in internal medicine at St. Vincent Hospital in Indianapolis, and Dr. Slama is chief of infectious diseases at St. Vincent Hospital and clinical associate professor of medicine at the Indiana University School of Medicine.

Correspondence and reprints: Thomas G. Slama, M.D., 10610 N. Pennsylvania, Indianapolis, IN 46260.

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Improved results with resection of extensive thoracoabdominal aneurysms

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Gilbert T. Herod, M.D.
John N. Pittman, M.D.
Spencer Goodson, M.D.
Harry Siderys, M.D.

Although there is general agreement that surgery should be considered for all patients with abdominal aortic aneurysms, physicians have been reluctant to refer patients with thoracic, and particularly thoracoabdominal, aneurysms for repairs. Operative mortality and the incidence and severity of complications have been perceived as prohibitive factors.

On the other hand, aneurysms enlarge and rupture regardless of their location. In studying the natural history of thoracic and abdominal aortic aneurysms, Estes¹ found that death from ruptured aneurysms occurred earlier in thoracic aortic aneurysms not treated surgically than in abdominal aneurysms.

The operative mortality in patients with extensive thoracoabdominal aneurysms has been reported as high as 50%.²

With extensive types of thoracoabdominal aneurysms, the aortic cross clamp times are

frequently longer than 30 minutes, increasing the risk of spinal cord or visceral ischemia. Therefore, one must rely on collateral circulation or other maneuvers to protect the spinal cord and viscera. Consequently, some investigators have employed adjunctive measures, such as spinal fluid drainage, in an effort to decrease the adverse effects of long ischemic intervals.³⁻⁹

We have adopted some new techniques designed to make surgery safer for these complicated aneurysms. We have succeeded in reducing the operative mortality to approximately that of surgery for abdominal aortic aneurysms and therefore are prepared to recommend surgery for all thoracic and thoracoabdominal aneurysms unless there is a medical contraindication.

The purpose of modifying the technique was to allow perfusion of as much of the distal portion of the body as possible via left heart bypass while surgeons work

Abstract

Thoracoabdominal aneurysms are the most extensive of aortic aneurysms, and their correction is associated with the greatest number of complications. The introduction of new techniques has reduced the morbidity and mortality of surgery for these formidable lesions. A description of some of these techniques, as applied to 33 patients, is summarized, and the results presented.

between two vascular clamps on the thoracic or abdominal aorta (*Figure*). In addition, separate cold perfusion of the spinal cord and viscera was performed for organ preservation.

The classic technique has been to clamp above and below the aneurysm (with or without distal perfusion) and then rapidly perform the complicated reconstruction. Our modification allows more deliberate implantation of the intercostal arteries (to protect the spinal cord) and later implantation of the visceral vessels.

Patient population

From March 1, 1990, through June 30, 1993, we operated on 33 patients with extensive thoracoabdominal aneurysms. Thirteen patients had associated dissections, and one patient had a ruptured aneurysm. Among our 33 patients, 18 were men and 15 were women. The mean age was 67, with a range of 38 to 79 years.

Eight patients (24%) were operated on either urgently or emergently because of rupture or dissections associated with their aneurysms.

A left thoracoabdominal incision was made through the fifth or sixth intercostal space. The left atrium and left femoral artery were cannulated to allow left heart bypass. The aorta was then clamped proximal to the aneurysm and a second clamp applied to the aneurysm approximately 10 cm distally. Left heart bypass was begun, and the distal body including viscera and spinal cord was perfused while the proximal aneurysm was opened, intercostals were sutured and a dacron graft was anastomosed to the aorta (Figure).

At this point, the proximal clamp was removed and another clamp applied at the level of the diaphragm, trapping the distal intercostal arteries (the common source of blood for the spinal cord). Perfusion with a specially prepared hypothermic solution was carried out to protect the spinal cord. This area of the thoracic aneurysm was then opened, and the intercostal arteries were attached to the graft. The same principle of sequential clamping, perfusing and repairing was continued down the aorta until the aneurysm repair was complete.

Results

The one postoperative death (3%) among the 33 patients occurred in the patient with a ruptured aneurysm. Three patients became paraplegic postoperatively, for an incidence of 9%. One patient developed renal failure, but his renal function recovered after one dialysis treatment.

Although the average blood utilization was 6.5 units of packed

cells, five patients (15%) did not use any blood products.

Discussion

Optimal methods to protect against spinal cord or visceral ischemia would intuitively include the following: 1) as brief a period of ischemia as possible; and 2) re-establishing direct perfusion to the spinal arteries and visceral arteries. Experimentally, Cohen et al have shown that clamping of the superior mesenteric artery for longer than 60 minutes increases the degree of disseminated intravascular coagulation.¹⁰ Postoperative bleeding secondary to coagulopathy is a well-known complication associated with thoracoabdominal aneurysm surgery.

Segmental cooling of the spinal cord and visceral arteries would also seem beneficial in decreasing the risks of spinal cord

or visceral ischemia. Some have advocated adding Mannitol and steroids to the cold Plasmalyte to reduce the harmful effects of post-ischemic reperfusion injury.¹¹

Potential disadvantages of left heart bypass include the need for heparinization. However, we have not identified or experienced any problems with disseminated intravascular coagulation with our technique, as described. We routinely monitored coagulation panels during the operation. In neither of the two patients who required reexploration for postoperative bleeding were any coagulation abnormalities identified.

Applying multiple clamps to the aneurysm may increase the risk of distal embolization from the aneurysm from the thrombus within the aneurysm. We did not observe any signs or symptoms indicative of embolus or microinfarcts.

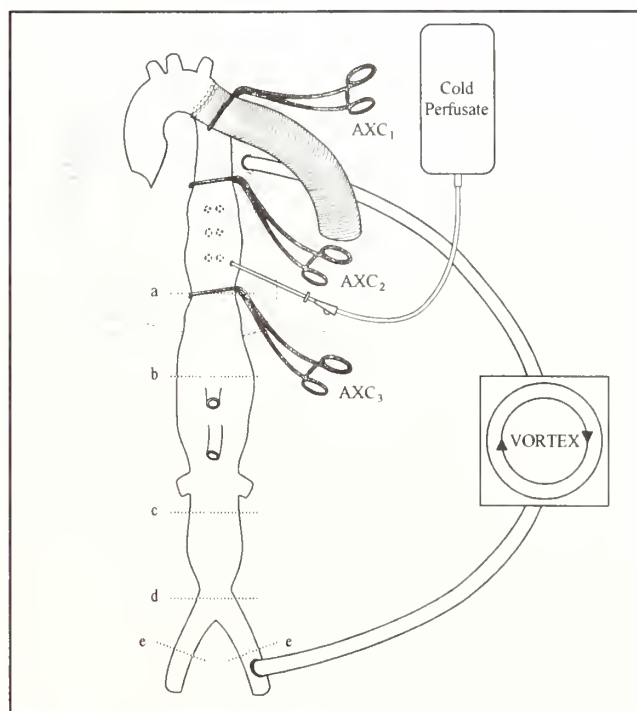


Figure: Portions of the aneurysm are segmentally clamped and resected, while the distal segment of the aorta continues to receive retrograde blood flow from the heart bypass.

In our technique, we have infused up to 2 liters of cold Plasmalyte, which has the potential to produce hypothermia with its many harmful effects. In addition, the long duration of these operations can add to the potential for hypothermia. However, the in-line heat exchanger allows the patient's temperature to be maintained between 35° and 37°C.

Our technique allows the operation to be carried out in an unhurried, deliberate fashion despite the extensive duration and complexity of these aneurysms, with an average operating time of 4.8 hours. This allows the surgeon to complete the anastomoses without being overly concerned about time.

Although our series is small, we have been encouraged by our results, especially among those patients with dissections associated with their extensive aneurysms, in whom a higher incidence of paraplegia and renal failure has been reported. ▴

The authors are with Cardiovascular Surgical Associates in Indianapolis.

Correspondence and reprints: John W. Fehrenbacher, M.D., Cardiovascular Surgical Associates, Methodist Hospital of Indiana, 1801 N. Senate Blvd., Indianapolis, IN 46202.

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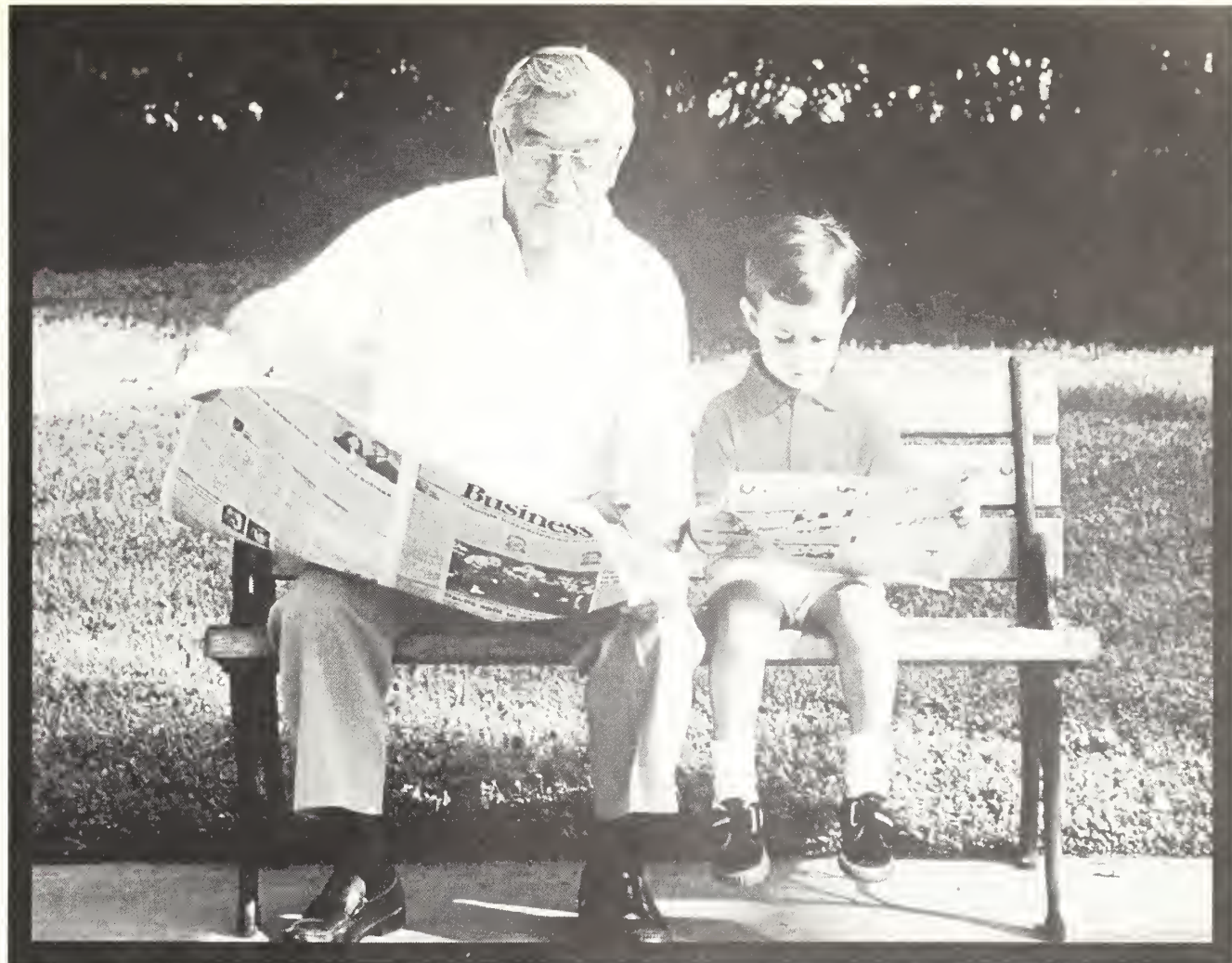
1993 Indiana State Medical Association membership report as of Dec. 31, 1993

	Active	Resident	Dues Exempt	Total
Adams	14	0	3	17
Bartholomew/Brown	95	4	18	117
Benton	1	0	1	2
Boone	14	1	11	26
Carroll	8	0	1	9
Cass	35	0	10	45
Clark	97	1	10	108
Clay	8	0	4	12
Clinton	16	0	3	19
Daviess/Martin	14	0	9	23
Dearborn/Ohio	37	0	3	40
Decatur	10	0	4	14
DeKalb	14	0	4	18
Delaware/Blackford	156	2	32	190
Dubois	38	1	4	43
Elkhart	135	0	35	170
Fayette/Franklin	23	0	4	27
Floyd	78	0	18	96
Fort Wayne (Allen)	466	39	99	604
Fountain/Warren	8	0	3	11
Fulton	7	0	1	8
Gibson	10	0	4	14
Grant	69	0	25	94
Greene	9	0	7	16
Hamilton	58	0	6	64
Hancock	28	0	9	37
Harrison/Crawford	14	0	1	15
Hendricks	49	0	6	55
Henry	21	0	11	32
Howard	98	1	28	127
Huntington	14	0	6	20
Indpls. (Marion)	1,601	50	314	1,965
Jackson	20	0	6	26
Jennings	4	0	1	5
Jasper/Newton	13	0	4	17
Jay	10	0	6	16
Jefferson/Switzerland	29	0	9	38
Johnson	50	0	8	58
Knox	55	0	13	68
Kosciusko	28	0	4	32
LaGrange	13	0	3	16

	Active	Resident	Dues Exempt	Total
Lake	613	4	118	735
LaPorte	113	0	26	139
Lawrence	41	0	8	49
Madison	132	0	36	168
Marshall	16	0	6	22
Miami	15	0	3	18
Monroe/Owen	167	1	23	191
Montgomery	31	0	9	40
Morgan	27	0	3	30
Noble	13	0	2	15
Orange	4	0	2	6
Perry	5	0	1	6
Pike	1	0	0	1
Porter	123	1	17	141
Posey	2	0	1	3
Pulaski	6	0	1	7
Putnam	11	0	5	16
Randolph	6	0	4	10
Ripley	12	0	0	12
St. Joseph	288	2	90	380
Scott	7	0	1	8
Shelby/Rush	27	0	6	33
Spencer	1	0	0	1
Starke	6	0	3	9
Steuben	10	0	6	16
Sullivan	3	0	5	8
Tippecanoe	184	1	46	231
Tipton	6	0	3	9
Vanderburgh	369	4	84	457
Vigo/Parke/Vermillion	136	0	33	169
Wabash	23	0	8	31
Warrick	16	0	0	16
Washington	8	1	1	10
Wayne/Union	90	0	28	118
Wells	37	0	15	52
White	4	0	4	8
Whitley	6	0	5	11
RMS	0	60	0	60
1993 totals	6,026	173	1,351	7,550
1992 totals	5,891	227	1,291	7,409

Membership information

1993	6,199	+ 81	1,351 (+60)	7,550
1992	6,118	+ 103	1,291 (+68)	7,409
1991	6,015	- 72	1,223 (+106)	7,238
1990	6,087	+ 68	1,117 (+29)	7,204
1989	6,019	- 75	1,088 (+76)	7,107



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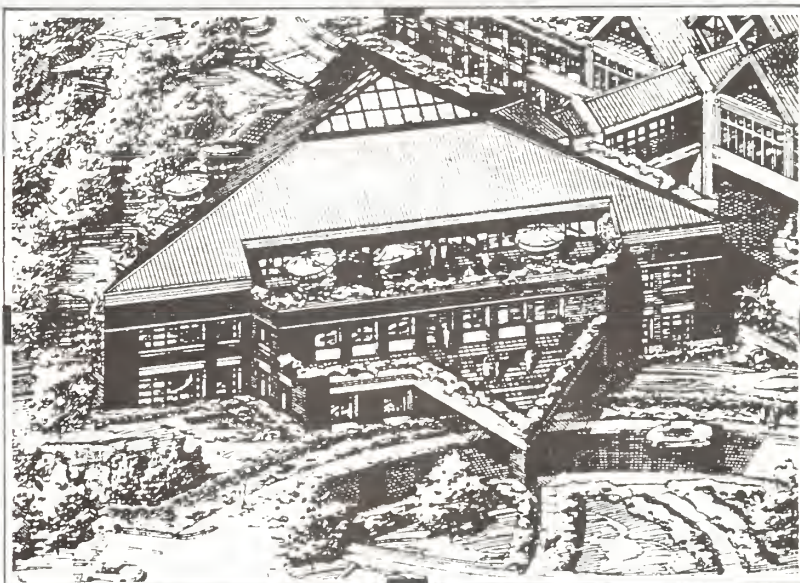
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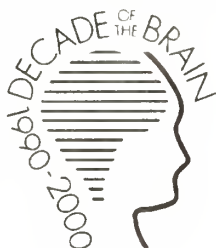
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■ alliance report

Marriage enrichment workshop draws favorable comments

Sue Ellen Greenlee, ISMA
Alliance president
Lucy Reed Foltyniak,
corresponding secretary

The marriage enrichment workshop sponsored by the ISMA and the Alliance was well-received, judging from participants' comments on the evaluation forms. Attendance at the workshop, held Feb. 25 to 27 in Lafayette, was greater than anticipated, in spite of the blizzard conditions on the opening evening. Here are a few comments from those who attended the workshop on "The Medical Marriage: Strengthening Couples' Ties to Each Other."

"Helped me understand how the ways we grew up impact my

marriage. I learned some more about my wife's family and looked more closely into mine."

"Opened some good dialogue between my spouse and me."

"Excellent speakers and programs. What we want to do is to get more time together."

"This meeting is an outlet for all the kinds of fears and frustrations we feel as medical families."

"Wanted more time to practice 'fair fighting.'"

"An excellent conference for married couples. Good job!"

"Should try to get grants to do this for medical students and residents."

"Every parent or spouse should have the opportunity to attend a workshop like this. It will not only help me in my marriage

and family life, but also in my practice."

"The 'practice' of family living will be enhanced for our family after this seminar. Addressed very important issues for everyday living, which are often lost in the busy schedule of a physician's family."

"We've been to parenting and marriage workshops before. We heard some of the same things, which were comforting, and learned some things too."

"Should be repeated – expanded next year."

"Do it again ... and make a Part II."

The alliance invites you to submit your comments or topics you would like presented at future workshops. □

Members explain reasons for non-renewals

Why do members not renew their ISMA alliance memberships? (Dues are \$18 per year.) To find out, the alliance sent a survey to non-renewing members in February. Here are some of the reasons given for non renewal:

- Meetings are always on weekdays.
- Dues costs keep going up.
- Too many demands on our retirement income.
- Alliance has become too social-oriented, rather than being active in projects.
- I wrote to county society to be put in touch with other physicians' spouses and no response.
- Want local level membership only.
- Not interested.
- No alliance in my county.
- Time and new baby.
- Tired of political issues.

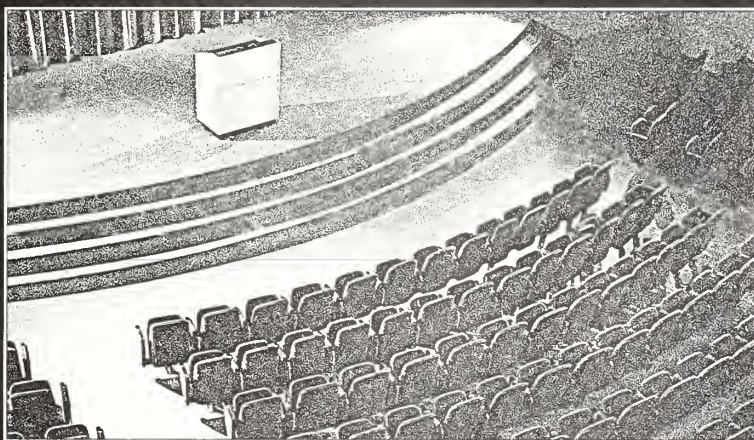
Here are some of the comments written on the survey:

"Somehow the younger spouses have to be made to feel it's important to belong ... made to feel or understand the need to get to know the other medical spouses in our community and being a part of the bigger organization and its projects. The friendships are so rewarding."

"There must be some contributions the older members can make – most of your meetings are geared for the under-50 crowd."

"Nature abhors a vacuum ... so one moves on to other things needing us more at this time."

These are thought-provoking comments. Membership is vital to the life of any organization, and we have to hear what our members need. All volunteer groups are losing their people. Our alliance is so unique – our partnership with our spouses makes us who we are. We need to support them and medicine and the medical community in these uncertain times. Can you help us? □



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■ from the museum

Central State closing won't affect museum

Oren S. Cooley
Indianapolis

The Indiana Medical History Museum in Indianapolis will remain open after Central State Hospital closes this year.

The museum, a private, non-profit organization, possesses a 99-year lease for the Old Pathology Building, which houses the museum, and the surrounding five acres on the grounds of Central State Hospital. This arrangement became possible because of Public-Law 245-1986 (HEA 1120).

In 1986, then Gov. Robert D. Orr signed legislation that gave the museum a four-year lease and, upon that document's expiration, a 99-year lease. The legislation also enabled the museum to acquire ownership of the building and its contents and to lease the property on which the museum stands for \$1 a year.

The Central Indiana Hospital for the Insane (now called Central State Hospital) originally opened its Pathological Department in 1896 to study the causes of mental and nervous disorders. "Physicians who have studied in the pathological laboratories of the old world [Europe] say that they have seen nothing to surpass it," noted the *Indianapolis Sentinel* when the building opened on Dec. 19, 1896.

Designed as a state-of-the-art research facility, the Pathological Department contained laboratories for pathologic anatomy, bacteriology, clinical chemistry and histology. The research conducted at this and similar facilities enabled physicians by the early decades of the 20th century to better under-

stand the physiological or natural causes of mental illness.

By the 1930s, these research laboratories failed to produce any more significant findings on mental illness, and eventually, most facilities closed. The buildings that housed the laboratories were either torn down or remodeled for other purposes. However, Central State Hospital did not close its Pathological Department but continued to use this building until the 1960s. During its history, few changes were made to the structure.

The Indiana Medical History Museum was established in 1969 to preserve this historic structure as well as the history of medicine in Indiana. Included on the National Register of Historic Places, the building represents not only the beginning of scientific psychiatry but also the beginning of modern scientific medicine.

Today the museum maintains a collection of more than 15,000 medical and health care artifacts from the 19th and early 20th centuries. The extensive collections include not only medical and surgical instruments, dental equipment, diagnostic instruments, pharmaceutical bottles and nursing uniforms but also homeopathic medicine cabinets, "quack" devices and patent medicine bottles.

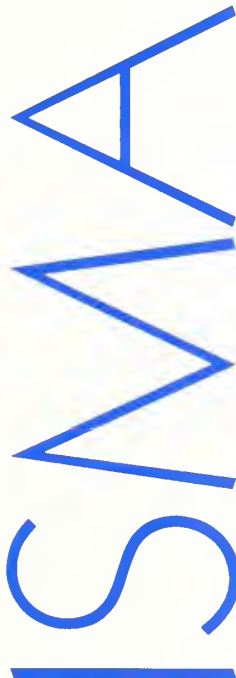
The museum is open from 10 a.m. to 4 p.m., Wednesday through Saturday, and other times by appointment. Admission to the museum is \$2 for adults, \$1 for students 18 years old and under, and free for children under 6 years old. For more information, call the Indiana Medical History Museum at (317) 635-7329. □

The author is director of the Indiana Medical History Museum.



The Indiana Medical History Museum once housed facilities to study mental disorders.

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■ cme calendar

Community Hospitals

Community Hospitals Indianapolis will present the "Fifth Annual Cardiovascular Symposium: Management Strategies for Primary Care Practitioners" Sept. 24 at the Embassy Suites in downtown Indianapolis.

For registration information, call Donna Grahn, (317) 355-5714.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology Inc., in cooperation with St. Vincent Hospital and Health Care Center, will present "Progress in Cardiology VII" May 20 at the Westin Hotel in Indianapolis.

For more information, call Janet MacAbee, (317) 871-6089.

Therapeutic ERCP

Education Design will present the third international "Hands-on Therapeutic ERCP Conference" June 10 through 12 in Baltimore, Md.

Maurice E. Arregui, M.D., of Indianapolis is a course director.

For more information, call Education Design at 1-800-832-5115.

Methodist Hospital

Methodist Hospital of Indiana will present the Sixth Annual Patrick A. Dolan Lecture June 10 at Methodist Hospital in Indianapolis.

The lecture will feature Orest Boyko, M.D., a neuroradiologist.

To register, call Wanda Giles at (317) 929-8250.

The Indiana Hand Center

The Indiana Hand Center in collaboration with St. Vincent Hospital will present "Treating Common Conditions of the Upper

Extremity: A Proactive Approach for Primary Physicians" Sept. 21 at The Indiana Hand Center in Indianapolis.

For registration information, call Kevin Essington at (317) 471-4394.

The Ear Institute

The Ear Institute of Indiana will present "Otology Update 1994," a mini-seminar on the ear, hearing and balance disorders, June 15 from noon to 5 p.m. at the Omni North Hotel in Indianapolis.

For more information, call (317) 842-4757 or 1-800-522-0734.

Hoosier Radiology

Hoosier Radiology, P.C. will present "MRI: Current Applications" June 5 at the Grand Wayne Center in Fort Wayne.

For more information, call Jessica Gize at (219) 424-6161.

American College of Cardiology

The American College of Cardiology will present these courses:

June 29-July 1 - International Symposium on Electrical Management of Cardiac Arrhythmias 1994, University Place Conference Center and Hotel, Indianapolis.

Sept. 19-21 - Advanced Echocardiography: Update 1994, University Place Conference Center and Hotel, Indianapolis.

For more information, call the American College of Cardiology at 1-800-257-4739.

Washington University

The Washington University School of Medicine in St. Louis will sponsor these CME courses:

May 20-21 - Cardiothoracic Anesthesia, St. Louis.

May 21 - Controversies in Contemporary Imaging, Marriott West, St. Louis.

For more information, call Cathy Sweeney, 1-800-325-9862.

University of Wisconsin

The University of Wisconsin School of Medicine will sponsor the following courses:

May 19-21 - 16th Annual Sports Medicine Symposium, Holiday Inn-West, Madison, Wis.

For more information, call Sarah Aslakson, (608) 263-2856.

George Washington

The George Washington University Medical Center will present these CME courses:

June 11-14 - Intensive Review of Internal Medicine, Washington Marriott, Washington, D.C.

June 11-15 - Second Annual Board Review Course in Family Medicine, Crystal Gateway Marriott Hotel, Arlington, Va.

June 19-22 - 10th Annual Meeting of the International Society of Technology Assessment in Health Care, Stouffer Harborplace, Baltimore, M.D.

For more information, call (202) 994-4285. □



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■ news briefs

Study reveals traits of successful PHOs

Successful physician hospital organizations (PHOs) share several common features, according to a recent case study analysis of PHOs. The study was conducted by the Indiana State Medical Association in conjunction with the American Medical Association, the Illinois State Medical Society and the Michigan State Medical Society.

As a result of on-site visits to eight PHOs, the following factors emerged as critical to the long-term success of PHOs:

- Committed physician and hospital leadership with a shared vision, clear goals and strategies and a keen understanding of the local health care market.
- A strong base of primary care physician support.
- A good geographic and specialty mix of physicians.
- An effective governance system, with shared control between the hospital and the physicians.
- Trust and collegiality between the hospital and the physicians.
- Adequate capitalization.
- Sophisticated information systems.
- Effective utilization management systems.
- Knowledgeable, dedicated staff.

The study was undertaken to answer such questions as "Are PHOs a viable concept?" "Can PHOs provide an organizational mechanism to meet the needs of patients, physicians, hospitals, business and payers?" and "Can PHOs be effective in a competitive, managed care environment?"

A complete report on the re-

sults of the study will be available later.

Hospital collaboration gets government OK

The U.S. Department of Justice has said that the proposed collaboration between Community Hospitals Indianapolis and St. Vincent Hospital in Indianapolis will not violate anti-trust laws.

The goal of collaboration is to provide a seamless delivery system that will reduce overall health care costs, improve quality and improve access to health care. Under the new arrangement, each hospital will keep its name, assets and individuality but will make planning, budgeting and operational decisions together.

Initially, task forces to identify and develop opportunities in collaboration will be working in cancer care, human resources, information systems, laboratory, mental health and occupational health.

Agreement pairs Ball Hospital and IUMC

Ball Memorial Hospital in Muncie and Indiana University Medical Center in Indianapolis have teamed up in an effort to enhance and expand the clinical programs, the graduate and undergraduate medical education programs and managed care contracting. The agreement also opens the way for the integration of hospital systems that would benefit both institutions.

The institutions already have joint programs for care of critically ill newborns and for diagnosis of complicated heart disorders that must be diagnosed by mapping the electrical function of the heart.

Officials hope that the affiliation will help attract more stu-

dents to primary care residencies.

Caylor-Nickel reaches out to rural residents

Caylor-Nickel Medical Center in Bluffton has begun a mobile-services outreach project to deliver primary care services to rural residents.

The program will operate jointly with the Community and Family Services agency, which administers the local Women, Infants & Children program. In addition, the program will include a research component to assess the needs of the surrounding rural population, including the Amish and migrant farm workers.

To deliver services to rural areas, the hospital has raised funds for a mobile services van, which will house an exam room, a computer system for gathering data, audio-visual equipment for health education programs and portable equipment for on-site tests. Two nurses, a nutritionist, a social worker and an intake specialist will staff the van.

Caylor-Nickel serves six northeast Indiana counties, covering 2,180 square miles.

Methodist Sports Medicine Center rated in top 10

The Methodist Sports Medicine Center in Indianapolis is rated among the top 10 sports medicine clinics in the United States, according to *Men's Journal* magazine.

The February issue of the monthly magazine said the 10 clinics were "widely considered to be among the best." Methodist was the only clinic within a 300-mile radius, with Cleveland and Detroit having the closest clinics listed.

Conferences to focus on health, violence, drugs

The Governor's Conference on Violence and Drugs and the Governor's Conference on Health will be held concurrently June 8 to 10 at the Indiana Convention Center in Indianapolis. Invited speakers for "Building Shared Visions" include Tipper Gore, wife of Vice-President Al Gore; C. Everett Koop, former U.S. surgeon general; Janet Reno, attorney general; and Carol Browner, Environmental Protection Agency.

George Rawls, M.D., Indianapolis, a former president of the Indiana State Medical Association, will speak on minority health.

Other topics will include health system reform, policy development, environmental health, collaborative partnerships, data analysis, violence and drugs. The event will feature 50 concurrent sessions, 10 round tables and 150 exhibits.

The health conference is sponsored by the Indiana State Department of Health. Sponsors of the conference on violence and drugs are the Indiana Criminal Justice Institute, the Department of Education, the Division of Mental Health, the Indiana Prosecuting Attorney's Council, the Office of Traffic Safety, the Attorney General's Office and the Governor's Commission for a Drug-Free Indiana.

The registration fee is \$55. For more information, call 1-800-878-8027.

MidWest changes name back to Winona

MidWest Medical Center in Indianapolis has taken back its original name of Winona Memorial Hospital.

Winona Hospital was established in 1956 by Dr. Joseph E. Walther, who named it after his mother, Winona McCampbell Walther.

The name was changed to MidWest Medical Center in 1991 when the hospital attempted to become a regional referral center. "The hospital lost sight of its mission as a community-based general facility. We are now back on track," said Keith King, hospital administrator. King said the hospital has trimmed costs where possible and established a management services organization to attract primary care physicians.

Ehlers named VP at Woodfield Company

Jerry Ehlers was named vice president of PPS Operations for The Woodfield Company. The Woodfield Company, a wholly-owned subsidiary of Physicians Insurance Company of Indiana, offers health care providers a claims filing Payment Procurement System (PPS).

PPS links participants to an electronic data interchange network. The system is designed to reduce the time-consuming burdens created by complex paper claims filing systems for government and commercial health plans. PPS is endorsed by the Indiana State Medical Association.

Childbirth education manual designed for disabled

A manual designed to provide physicians and nurses with information about childbirth education for women with disabilities is available from the Ohio State University Medical Center.

The 231-page manual, "Childbirth Education for Women with Disabilities and Their Partners," addresses sight and hearing impairments, rheumatoid arthritis, systemic lupus erythematosus, post-polio effects, spinal cord injuries, cerebral palsy and mental retardation. The first two sections are designed for the childbirth educator, while the third section is written in large print and simplified language so it can be used with women with mental retardation.

The manual is \$65. To order a copy, call Debbie Cheatham at (614) 292-9670.

Publication lists AIDS drugs in development

The Pharmaceutical Manufacturers Association has issued a publication summarizing the latest drug developments in the fight against AIDS.

The publication features charts listing drugs that are in the clinical trials stage and drugs that have been approved in the prevention, cure or treatment of AIDS and AIDS-related conditions.

Copies of the publication are available from the Pharmaceutical Manufacturers Association, 1100 15th St. NW, Washington, DC 20005, (202) 835-3400. □

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1 – Barney R. Maynard, Evansville (1995)
*2 – Jerome E. Melchior, Vincennes (1996)
3 – Gordon L. Gutmann, Jeffersonville
(1994)
4 – Arthur C. Jay, Lawrenceburg (1995)
5 – Fred E. Haggerty, Greencastle (1996)
6 – Ray A. Haas, Greenfield (1994)
7 – Ron Stegemoller, Danville (1995)
7 – John M. Records, Franklin (1996)
7 – Bernard J. Emkes, Indianapolis (1994)
8 – John V. Osborne, Muncie (1996)
9 – Stephen D. Tharp, Frankfort (1994)
10 – Thomas A. Brubaker, Munster (1995)
11 – Laurence K. Musselman, Marion
(1996)
12 – Joseph R. Manthey, Bluffton (1994)
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RMS – Ruchir Sehra, Indianapolis (1994)
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(1994)
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2 – James P. Beck, Washington (1995)
3 – John H. Seward, Bedford (1995)

4 – Lawrence R. Bailey Jr., Aurora (1994)
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6 – Howard C. Deitsch, Richmond (1995)
7 – Frank Johnson, Indianapolis (1994)
7 – Paula A. Hall, Mooresville (1995)
7 – Girdhar Ahuja, Indianapolis (1996)
8 – Susan K. Pyle, Union City (1994)
9 – Daniel Berner, Lafayette (1995)
10 – John L. Swarner, Valparaiso (1994)
11 – Regino B. Urgena, Marion (1995)
12 – Brenda S. Stiles, Fort Wayne (1995)
13 – Richard J. Houck, Michigan City
(1994)
RMS – Glenn A. Loomis, Indianapolis
(1994)
MSS – Michael Hardacre, Miller Beach
(1994)

AMA DELEGATES (Terms end Dec. 31)

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John D. MacDougall, Indianapolis (1995)
Michael O. Mellinger, LaGrange (1995)
John A. Knot, Lafayette (1994)
Shirley Khalouf, Marion (1994)
George T. Lukemeyer, Indianapolis (1994)

AMA ALTERNATE DELEGATES

(Terms end Dec. 31)

Barney Maynard, Evansville (1995)
George Rawls, Indianapolis (1995)
William Beeson, Indianapolis (1995)
Max N. Hoffman, Covington (1994)
C. Dyke Egnatz, Schererville (1994)
Alfred Cox, South Bend (1994)

DISTRICT OFFICERS & MEETINGS

1 – Pres: Rex Ragsdale, Evansville
Secy: John Berry, Evansville
Annual Meeting: May 19, 1994
2 – Pres: Tom Sharp, Bloomington
Secy: Robert Hongen, Bloomington
Annual Meeting: May 12, 1994
3 – Pres: Steve Barlow, Bedford
Secy: Alan Smith, Bedford
Annual Meeting: May 18, 1994
4 – Pres: Barbara Taylor, Greensburg
Secy: Angie Fontanilla, Greensburg
Annual Meeting: May 4, 1994
5 – Pres: James Walsh, Terre Haute
Secy: Rahim Farid, Brazil
Annual Meeting: May 26, 1994
6 – Pres: William Toedebusch, Richmond
Secy: Mark Lemmons, Greenfield
Annual Meeting: May 11, 1994
7 – Pres: Paula Hall, Mooresville
Secy: John Schneider, Indianapolis
Annual Meeting: June 29, 1994

8 – Pres: Susan Pyle, Union City
Secy: Jerome M. Leahey, Union City
Annual Meeting: June 1, 1994
9 – Pres: Irene Gordon, Lafayette
Secy: Stephen D. Tharp, Frankfort
Annual Meeting: June 8, 1994
10 – Pres: John L. Swarner, Valparaiso
Secy: Anil Kothari, Valparaiso
Annual Meeting: April 30, 1994
11 – Pres: William D. Dannacher, Wabash
Secy: Jack Higgins, Kokomo
Annual Meeting: Sept. 14, 1994
12 – Pres: Joseph Manthey, Bluffton
Secy: Brenda Stiles, Fort Wayne
Annual Meeting: Sept. 15, 1994
13 – Pres: Alan H. Bierlein, Bristol
Secy: John W. Schurz, South Bend
Annual Meeting: March 23, 1994

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ARNETT CLINIC

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In eight outpatient facilities, over 110 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The majority of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 320,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Managed Health Plans and the corporate affiliate of Arnett Pharmacy.

Practice Setting

At this time, over 110 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For further information...

about Arnett Clinic and physician employment opportunities contact:

Physician Recruitment Department
Arnett Clinic, 2600 Greenbush Street
Lafayette, IN 47904 (317) 448-8000
Toll Free Nationwide, 1-800-899-8448



Lafayette, Indiana

■ obituaries

Milton L. Bankoff, M.D.

Dr. Bankoff, 75, a retired Michigan City general practitioner, died Jan. 12, 1994, at his home.

He was a 1943 graduate of the New York University School of Medicine.

Dr. Bankoff, who retired in 1988, had practiced in Michigan City since 1944. He also had served as deputy chief of the nursing home branch of the Division of Medical Care of the Department of Health, Education and Welfare and as director of the division's group practice program. While in Washington, D.C., he worked on the Community Health Program, which provided quality medical care to inner city residents. He was a past president of Doctors Hospital, the predecessor to Memorial Hospital, and a co-founder of Michigan City Medical Group. Dr. Bankoff also was a co-founder of Woodview Rehabilitation Center, a past president of the LaPorte County Medical Society and a fellow of the American Academy of Family Physicians.

James V. Cortese, M.D.

Dr. Cortese, 83, an Indianapolis family practice physician, died Feb. 6, 1994.

He was a 1949 graduate of the Case Western Reserve University School of Medicine.

Dr. Cortese, who operated the Cortese Clinic for 45 years, retired in 1986. In 1963, he founded University Heights Hospital, which later became Community Hospital South. He served 12 years on the board of trustees of the Marion County Health and Hospital Corp., was physician for the Marion County court system 10 years and was a Marion County deputy coroner 10 years. He was a

charter fellow of the American Academy of Family Physicians.

William T. Douglas, M.D.

Dr. Douglas, 77, a retired Indianapolis anesthesiologist, died March 4, 1994.

He was a 1943 graduate of the Indiana University School of Medicine.

Dr. Douglas, who practiced anesthesiology 42 years, had been affiliated with Winona Memorial Hospital. He retired in 1990.

Max Ganz, M.D.

Dr. Ganz, 83, a retired Marion family practice physician, died Feb. 2, 1994, in the Cleveland Clinic Hospital in Fort Lauderdale, Fla.

He was a 1936 graduate of the Indiana University School of Medicine and an Army Air Corps veteran of World II. He was awarded the Bronze Star.

Dr. Ganz retired in 1988, after more than 50 years in practice. He was born in Russia and left the country with his parents after the Russian Revolution, settling in Marion in 1924. He served on the Marion City Health Board and had been chief of staff and on the board of directors of Marion General Hospital. During his half century in practice, he once estimated that he had delivered more than 8,000 babies. Dr. Ganz enjoyed playing the violin and in 1985 formed a musical group of physicians and other friends, known as the Fantastic Fiddlers.

John H. Greist, M.D.

Dr. Greist, 88, a retired Indianapolis psychiatrist, died March 5, 1994.

He was a 1929 graduate of the Indiana University School of Medicine and an Army veteran of

World War II.

Dr. Greist was past chairman of the psychiatry staff at Methodist Hospital and a clinical professor emeritus at the IU School of Medicine. He established the electroencephalography laboratory at Methodist Hospital in 1947 and directed that service until 1966. He was a past chairman of the board of the Indiana Mental Health Association and a past president of the Indiana Mental Health Memorial Foundation. Dr. Greist was a life fellow of the American Psychiatric Association and the Central Neuropsychiatric Association.

Stephen Hermayer, M.D.

Dr. Hermayer, 78, an Evansville ophthalmologist, died Feb. 2, 1994, at his home.

He was a 1942 graduate of the State University of New York and a veteran of World War II.

Dr. Hermayer had served on the staffs of Deaconess, St. Mary's and Welborn Baptist hospitals. He was a member of the American Academy of Ophthalmology. He was a violinist with the Evansville Philharmonic for 24 years.

Francis J. Kubik, M.D.

Dr. Kubik, 82, a retired Michigan City surgeon, died Dec. 25, 1993, at his home.

He was a 1940 graduate of the Indiana University School of Medicine, where he was first in his class.

Dr. Kubik had served as president of the American Society of Abdominal Surgeons and on the Indiana board of Blue Cross-Blue Shield. He also had been a member of the LaPorte County Board of Health.

Eddie T. Pappas, M.D.

Dr. Pappas, 68, a Merrillville family physician, died Feb. 23, 1994, at his home.

He was a 1956 graduate of the Indiana University School of Medicine.

Dr. Pappas was a staff member at St. Mary Medical Center, St. Anthony Medical Center and Methodist Hospitals in Lake County. He had served as an instructor at the Northwest Center for Medical Education. Dr. Pappas was parish council president of SS. Constantine & Helen Greek Orthodox Cathedral for two years and was awarded the title of Archon of the Orthodox Church under the Ecumenical Patriarchate.

Frank W. Peyton, M.D.

Dr. Peyton, 84, a retired Lafayette obstetrician and gynecologist, died Dec. 23, 1993, in Home Hospital in Lafayette.

He was a 1934 graduate of the University of Colorado School of Medicine and served in the Army Medical Corps during World War II. He wrote *A Surgeon's Diary*, a record of his military experiences in Africa, Sicily and Italy.

Dr. Peyton, who practiced in Lafayette from 1937 until his retirement in 1992, planned and built three specialty clinics, including the Lafayette Woman's Clinic, Indiana's first team practice dedicated specifically to women's health. He delivered more than 11,000 babies and performed more

than 10,000 surgeries during his career. He was a member and past president of the Indiana Obstetrical and Gynecological Society and had served on the board of directors of Home Hospital and Lyn Treece Boys Club. Dr. Peyton was a diplomate of the American Board of Obstetricians and Gynecologists and a fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons.

H. Dale Pyle, M.D.

Dr. Pyle, 93, a retired South Bend pediatrician, died Jan. 28, 1994, in Royal Oak Care Center in Sun City, Ariz.

He was a 1925 graduate of the Indiana University School of Medicine. He was a Navy veteran of World War I and served in the Army Medical Corps during World War II.

Dr. Pyle was a pediatrician in South Bend for four decades. He had served as president of the South Bend Medical Foundation and of the medical staff at Memorial Hospital.

William Renforth, M.D.

Dr. Renforth, 63, a Connersville family physician, died Jan. 3, 1994, at his home.

He was a 1966 graduate of the West Virginia University School of Medicine.

Charles F. Seaman, M.D.

Dr. Seaman, 81, a retired internist, died Jan. 2, 1994. Formerly of Frankfort, he had been living in Summit, N.J.

He was a 1938 graduate of the Northwestern University School of Medicine and an Army veteran of World War II.

Dr. Seaman retired from private practice in 1973. Previously, he was an emergency physician at Community Hospital in Indianapolis.

J. William Wright Jr., M.D.

Dr. Wright, 77, a retired Indianapolis otolaryngologist, died Feb. 14, 1994.

He was a 1942 graduate of the University of Michigan Medical School and an Army Air Forces veteran of World War II.

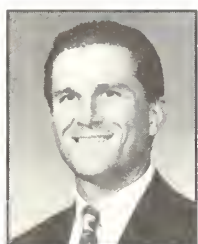
Dr. Wright had served on the medical staff of Community Hospitals Indianapolis and had been an associate professor in the department of otolaryngology at the Indiana University School of Medicine. He had served as president of the American Council of Otolaryngology, the Indiana Academy of Otolaryngology and Ophthalmology, the Indiana Medical Federation, the Wright Institute of Otolaryngology and the National Hearing Association. Dr. Wright had been a member of the malpractice advisory commission of the ISMA and the presidential advisory committee of the American Academy of Otolaryngology. □



Dr. Glazer

D^{r.} Barry M. Glazer of Indianapolis was elected president of the Indiana Society of Anesthesiologists and will serve from 1994 to 1996; he

also is serving his fourth term as vice speaker of the house of delegates of the American Society of Anesthesiologists. Other new officers are **Dr. Larry G. Thompson** of South Bend, president elect, and **Dr. Gerard T. Costello** of Muncie, secretary-treasurer.



Dr. Idler

Recent accomplishments and activities of physicians at The Indiana Hand Center include the following: **Dr. Richard Idler** lectured on "Use of the

Gamow Bag in the Treatment of Acute Mountain Sickness" at the Outdoor Pursuits Program at the University of Calgary; he will serve as trip physician when program members travel to Mount Mercurio, Chile, in November. Dr. Idler spoke on "Tenosynovitis/Epicondylitis" during American Society for Surgery of the Hand Specialty Day as part of the annual American Academy of Orthopaedic Surgeons meeting in New Orleans. **Dr. James W. Strickland**, chairman of hand surgery at St. Vincent Hospital, was named first vice-president of the American Academy of Orthopaedic Surgeons. **Dr. Hill**

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

January 1994

Anderson, James T., Greenfield
Baugh, David O., Danville
Beeler, Richard T., Carmel
Bever, Jonathan H., Columbus
Boyd, Carl R., Logansport
Chaudhry, Shaikat A., Mishawaka
Doepker, John F., Evansville
Hennessee, Samuel D., Carmel
Hobbs, Hudner L., Indianapolis
Massuda, Yacoub, Valparaiso
Palmer, Robert M., Indianapolis
Probst, Edward L., Columbus
Raju, Mudunuri V., Greencastle
Scheurich, Manley K., Oxford
Swanson, Richard T., Evansville
Trammell, Terry R., Indianapolis

February 1994

Alvis, David L., Indianapolis

Ayoub, Adel H., Valparaiso
Balamohan, Ramalingam, Bluffton
Booth, Franklin M., South Bend
Gaud, Ramesh S., Rensselaer
Hall, Donald L., Petersburg
Lee, Truman H., Indianapolis
Liebschutz, Norman H., Indianapolis
Mealey, John, Indianapolis
Monn, Larry N., Indianapolis
Moore, Thomas S., Indianapolis
Paff, James R., Kokomo
Porcaro, Joseph P., Anderson
Renshaw, Mark A., Fort Wayne
Robbins, Gordon T., Zionsville
Sharp, Thomas W., Bloomington
Siwy, Barbara K., Indianapolis
Sowers, Bruce K., Fort Wayne
Zollman, Charles W., Indianapolis

Hastings II spoke on "Surgical Management and Treatment of Elbow Contractures" at the annual meeting of the American Academy of Orthopaedic Surgeons in New Orleans; during Specialty Day for the American Shoulder and Elbow Surgeons, he presented his paper on "Vascularized Distal Radius Bone Grafting of Scaphoid Nonunions," and his paper on "Rotatory Instability of the Elbow: The Lateral Stabilizers" was presented by co-author Dr. Mark Cohen.

Dr. Margaret Frazer, affiliated with Hoosier Neurology in Indianapolis, has given more than 75 talks on "Medical Management of Alzheimer's Disease" during a

lecture circuit along the East Coast. Her lectures were made possible through a grant from Parke-Davis.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke on "Cheek Augmentation Using a Transconjunctival Approach" and "Tip Alignment with Alar On-Lay Grafts" during a winter symposium in Aspen, Colo., sponsored by the American Academy of Facial Plastic Surgery. He also participated in a panel discussion on complex rhinoplasty.

Dr. Thomas A. Ambrose II, **Dr. Robert J. Huler** and **Dr. Harlan T. Stratton**, all of Indianapolis, were inducted as fellows of the American Academy of Orthopaedic Surgeons.

Dr. Debra J. Myers, an Indianapolis pulmonary diseases specialist, has been board certified in critical care medicine.

Dr. David A. Fisher of Orthopaedics Indianapolis presented "Cost Containment in Total Joint Surgery" on grand rounds at Erie County Medical Center in Buffalo, N.Y.

Dr. Andrew J. Vicar of Orthopaedics Indianapolis spoke on "Treatment and Results of Grade 3 Open Fractures of the Upper Extremity" at the Garceau-Wray Lectures in Indianapolis; the article was published in the Fall 1993 issue of *Orthopaedic Trauma Update*.

Dr. Manfred Mueller and **Dr. Robert Shellman**, Indianapolis specialists in pulmonary and sleep disorders medicine, have opened the Center for Respiratory Medicine in the St. Francis Medical Arts Building in Beech Grove.

Activities and accomplishments of physicians affiliated with Nasser, Smith & Pinkerton Cardiology in Indianapolis include the following: **Dr. William K. Nasser** spoke at a seminar on "Cardiovascular Reform - The Future of Cardiology" in Phoenix. **Dr. Bruce Waller** spoke on "Pathophysiology of PTCA" at a seminar on Update on Experimental Results and Clinical Interventions in Garmisch-Partenkirchen, Germany. Feb. 23 was declared **Dr. Robert Cunningham** Day at Marion General Hospital in celebration of the 25th anniversary of the coronary care unit; Dr. Cunningham was co-developer and is director of the unit.

Dr. Annemarie P. DeSanto, a Kokomo general surgeon, received a three-year appointment as cancer liaison physician for the Hospital Cancer Program at Howard

Community Hospital.

Dr. Edward L. Langston, formerly of Indianapolis, was appointed to the John S. Dunn Sr. Chair in Family Practice at the Memorial Healthcare System in Houston, Texas.

Dr. Beatrice M. Hernandez, an oncologist at LaPorte Hospital, received a three-year appointment as cancer liaison physician for the hospital's cancer treatment center.

Dr. Richard S. Mayrose, a family practice physician, was named chief of staff at Union Hospital in Terre Haute. Other officers are **Dr. Robert F. Rourke**, an obstetrician and gynecologist, president of the medical and

dental staff, and **Dr. Iradj Noroozi**, an obstetrician and gynecologist, vice-president.

Dr. Andrew P. Garlisi, an emergency physician at St. Anthony Hospital in Michigan City, was appointed to the LaPorte County Health Board.

Dr. Michael R. Engle of Fort Wayne and **Dr. Erin C. Snyder** of New Albany were named diplomates of the American Board of Family Practice.

Dr. Jon W. Holdread of Columbus was elected a fellow of the American Psychiatric Association.

Dr. Raymond W. Nicholson of Evansville was named to the

Indiana University medical student honored

John S. Oester, a student at the Indiana University School of Medicine, was honored as one of 50 outstanding young medical professionals by the American Medical Association. He received the AMA/Glaxo Achievement Award, presented to 25 medical students and 25 residents, at the annual AMA leadership conference.

Oester, of Fort Wayne, was recognized for his extensive leadership in college as the recipient of the student Government Outstanding Leadership Award. An active member of the AMA Medical Student Section Chapter, he received full scholarships for both college and medical school education.

Each winner received a grant to attend educational and informational sessions at the leadership conference in San Francisco. □



Lonnie Bristow, M.D., right, chairman of the AMA board of trustees, congratulates **John S. Oester** for receiving an AMA/Glaxo Achievement Award.

■ people

committee on health education of the American Academy of Family Physicians.

Dr. Ray L. Henderson, an Indianapolis cardiologist, was elected president of the Indiana affiliate of the American Heart Association, and **Dr. Timothy Story**, an Indianapolis internist, was elected vice-president.

Dr. Donn R. Hunter of Greenfield was named physician recruitment/retention manager at Hancock Memorial Hospital.

Dr. James R. Daggy, a Richmond family practice physician, was elected first vice-president of the Area 9 Agency on Aging.

Dr. John P. Smith of Bluffton has retired after nine years with the Caylor-Nickel Clinic. Previously, he was in the U.S. Naval Service for 21 years.

Dr. David W. Dobbs, a Lawrenceburg family practice physician, was elected chief of the Dearborn County Hospital medical staff. Other officers are **Dr. Gregory E. Heaton**, pathologist, chief of staff-elect, and **Dr. Jim D. Swanson**, orthopaedic surgeon, secretary-treasurer.

Dr. Warren C. Hauck, a Fort Wayne gastroenterologist, was elected president of the Parkview Memorial Hospital medical staff. Other officers are **Dr. Richard A. Kelty**, family practice physician, president-elect, and **Dr. David T. Sowden**, thoracic surgeon, secretary/treasurer.

Dr. John H. Fallon, **Dr. Nancy K. Hockley** and **Dr. David W. Stein**, all of Fort Wayne, were named fellows of the American College of Surgeons.

Dr. O.T. Gordon, an Indianapolis gastroenterologist, was elected president of the Indianapolis chapter of 100 Black Men, a non-profit group working to

alleviate the problems facing Indianapolis, especially those affecting African-American men. **Dr. Frank P. Lloyd Jr.**, an Indianapolis oncologist, was elected vice-president.

Dr. Herbert O. Chattin, a Vincennes family practice physician since 1946, has retired.

Dr. John S. Wilson has retired after 36 years as a family practice physician in Columbia City.

New ISMA members

Ronald J. Barrette, D.O., Wabash, general surgery.

James T. Baumberger, M.D., Beech Grove, family practice.

Kathy L. Baumberger, M.D., Beech Grove, family practice.

Douglas J. Boss, M.D., Goshen, family practice.

Elizabeth S. Bowman, M.D., Indianapolis, psychiatry.

Daniel S. Brown, M.D., Ferdinand, family practice.

David M. Brown, D.O., Portland, emergency medicine.

William B. Camm, M.D., Indianapolis, internal medicine.

Randall J. Cammenga, M.D., Elkhart, emergency medicine.

Hope M. Chema, M.D., Indianapolis, family practice.

Jeffrey M. Collier, M.D., Indianapolis, family practice.

Diane S. Cook, M.D., Wakarusa, family practice.

Gary L. Crawley, M.D., Anderson, psychiatry.

Marc Alan Darst, M.D., Portland, family practice.

Keith Dinkluge, M.D., New Castle, family practice.

Clem M. Doxey III, M.D., Indianapolis, orthopaedic surgery.

Umar M. Dugar, M.D., Evansville, ophthalmology.

Scott B. Edwards, M.D., South Bend, occupational medicine.

Robert H. Falender, M.D., Beech Grove, orthopaedic surgery.

Evan R. Farmer, M.D., Indianapolis, dermatology.

Joseph F. Faust, M.D., Fort Wayne, ophthalmology.

June M. Ferguson, M.D., Mishawaka, family practice.

James K. Fitzpatrick, M.D., Merrillville, urological surgery.

Michael S. Fitzpatrick, M.D., Jeffersonville, anesthesiology.

Abel A. Garibaldi, M.D., Griffith, cardiovascular surgery.

Dale A. Goodman, M.D., LaPorte, anesthesiology.

Thomas E. Gutwein, M.D., Fort Wayne, emergency medicine.

Robert J. Havlik, M.D., Indianapolis, plastic surgery.

Thomas A. Hawk, M.D., Mooresville, anesthesiology.

Lynette Hazelbaker, M.D., Kokomo, internal medicine.

Joyce A. Heald, M.D., Elkhart, emergency medicine.

William A. Heisel, M.D., Carmel, emergency medicine.

John B. Hittle, M.D., Greenfield, internal medicine.

Charles D. Hodges Jr., M.D., Indianapolis, family practice.

Daniel J. Hurley, M.D., Indianapolis, internal medicine.

Geilan Ismail, M.D., Lafayette, cardiovascular diseases.

David M. Kaehr, M.D., Indianapolis, orthopaedic surgery.

Thomas K. Kalmbach, M.D., Valparaiso, cardiovascular surgery.

Kambiz T. Karimi, M.D., Indianapolis, internal medicine.

Michael L. Kramer, M.D., Danville, orthopaedic surgery.

Otto Kunst, M.D., Bluffton, diagnostic radiology.

Lawrence Merion Manuel Lavine, M.D., Madison, anesthesiology.

Madeline R. Lewis, D.O.,

South Bend, family practice.

K. Gregory Lucchesi, M.D., Chicago, anesthesiology.

Kenneth M. Maynard, D.O., Brownsburg, family practice.

Lou Ann McAdams, M.D., Fishers, family practice.

Kelly S. Miller, M.D., Indianapolis, family practice.

Carl E. Otten, M.D., Indianapolis, occupational medicine.

Minesh B. Patel, M.D., Michigan City, internal medicine.

Michael S. Pizzato, D.O., Brownsburg, family practice.

Patrick S. Reisinger, M.D., Indianapolis, internal medicine.

Crisanto M. Reyes, M.D.,

Bloomfield, internal medicine.

Todd A. Rhoades, M.D., Anderson, family practice.

Edward A. Rothschild II, M.D., Louisville, Ky., anesthesiology.

Michael E. Ruff, M.D., Jasper, pediatrics.

Hemant Sabharwal, M.D., Indianapolis, hand surgery.

Alan L. Schwartz, M.D., Indianapolis, pediatrics.

Aki Selky, M.D., Indianapolis, ophthalmology.

Mark Shina, M.D., New Albany, general surgery.

Jack C. Siebe, M.D., Bloomfield, family practice.

Satyanarayana Tatineni, M.D., Evansville, cardiovascular diseases.

Jeffrey E. Van Hove, M.D., Muncie, vascular and interventional radiology.

Gordon Vogel, M.D., Mount Vernon, internal medicine.

James E. Whitfield Jr., M.D., Kokomo, family practice.

Beth E. Yeagerlehner, M.D., Martinsville, family practice.

Vicki K. Yost, M.D., South Bend, family practice.

Edwin C. Zamber, D.O., Zionsville, general practice. ▴

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THE DEPARTMENT OF RADIATION ONCOLOGY, Indiana University School of Medicine, has a clinical faculty position open. Candidates should have a strong clinical and teaching background and must be board certified or eligible. Send curriculum vitae to Marcus E. Randall, M.D., Chairman, Department of Radiation Oncology, Indiana University School of Medicine, 535 Barnhill Drive, Room 071, Indianapolis, IN 46202. Indiana University is an Equal Opportunity/Affirmative Action Employer, M/F.

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Advertising index

AdminaStar	Cover
Arnett Clinic	251
Auto Purchasing Unlimited	207
Bethesda Group Practice	260
Central Pharmaceuticals	183
Fifth Third Bank	225
Franciscan Placement Service	260
HBI Recruiter	211
ISMA Insurance Agency	241, 245, Cover
Indiana University Medical Center	247
James Cancer Hospital	194, 195
Medical Protective	261
Palisades Pharmaceuticals	182
Physicians' Directory	226
Physicians Insurance Co. of Indiana	Cover
Practice Management for Professionals	207
Price, T. Rowe	213
Reeves Hummer	219
Rehabilitation Hospital of Indiana	223
Schering Corporation	206, 207
Shore, M.E., CPA	201
The Money Store	185
University Place	243
Wallace Funding	257
Xerox	205

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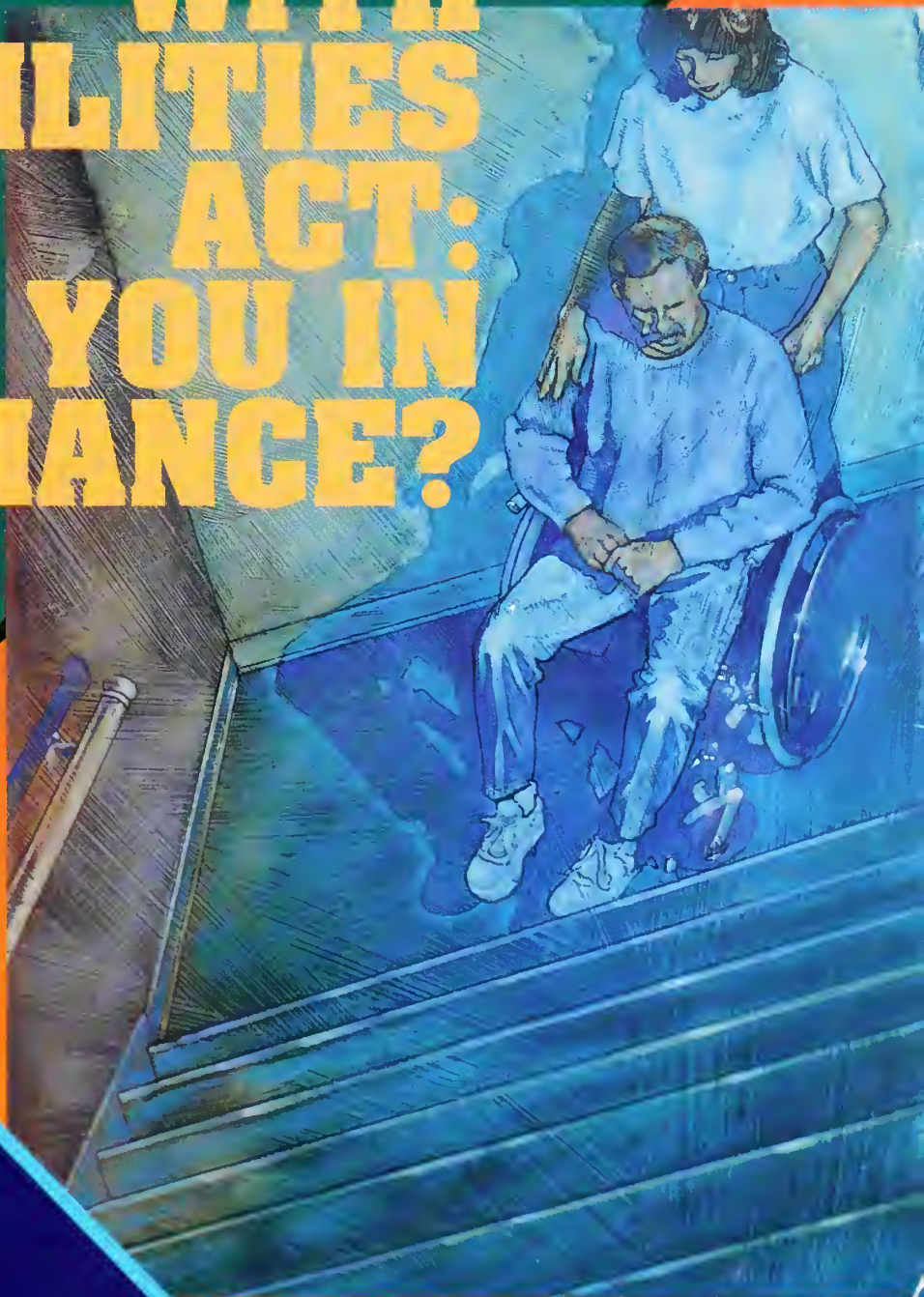
INDIANA MEDICINE

The Journal of the Indiana State Medical Association

July/August 1994

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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

July/August 1994

Vol. 87, No. 4

features

Doctors, state can be partners in reform 270
INDIANA MEDICINE interviews Myra Selby, Indiana's director of health care policy, on the state's initiatives in health system reform.

**Americans with Disabilities Act:
Are you in compliance?** 276
Physicians who demonstrate sensitivity to the needs of their employees and patients with disabilities have taken the first step toward complying with this federal law.

**The 10 most important clauses
in a managed care contract** 284
Physicians may want to read this helpful checklist before they sign another managed care contract.

**Managed competition means more
group physician practices** 288
Health system reform is resulting in the growth of group practices.

**Digest of health and medical laws:
1994 Indiana General Assembly** 290
This overview of the legislative session describes changes in state policies that will affect physicians and their patients.

Avoiding the 10% early retirement penalty 296
There are several ways for physicians to access their retirement funds before age 59 1/2 without paying a penalty.

Wishard plaque honors pioneer hip surgeon 298
Tribute is paid to the orthopaedic surgeon at the Indiana University School of Medicine who performed the first hip implant.

scientific contribution

A survey of mycobacteriology
laboratory practice in Indiana 300



Cover story begins on page 276. Painting reproduced by permission of Rehabilitation Hospital of Indiana and Communico. Cover design by Diane Alfonso of Indianapolis.

departments

stethoscope 266
letter to editor 268
alliance report 320
from the museum 322
cme calendar 324
isma leadership 326
obituaries 328
people 330
classifieds 334

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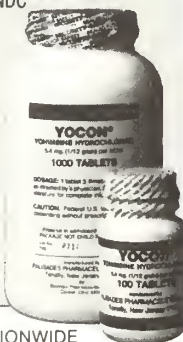
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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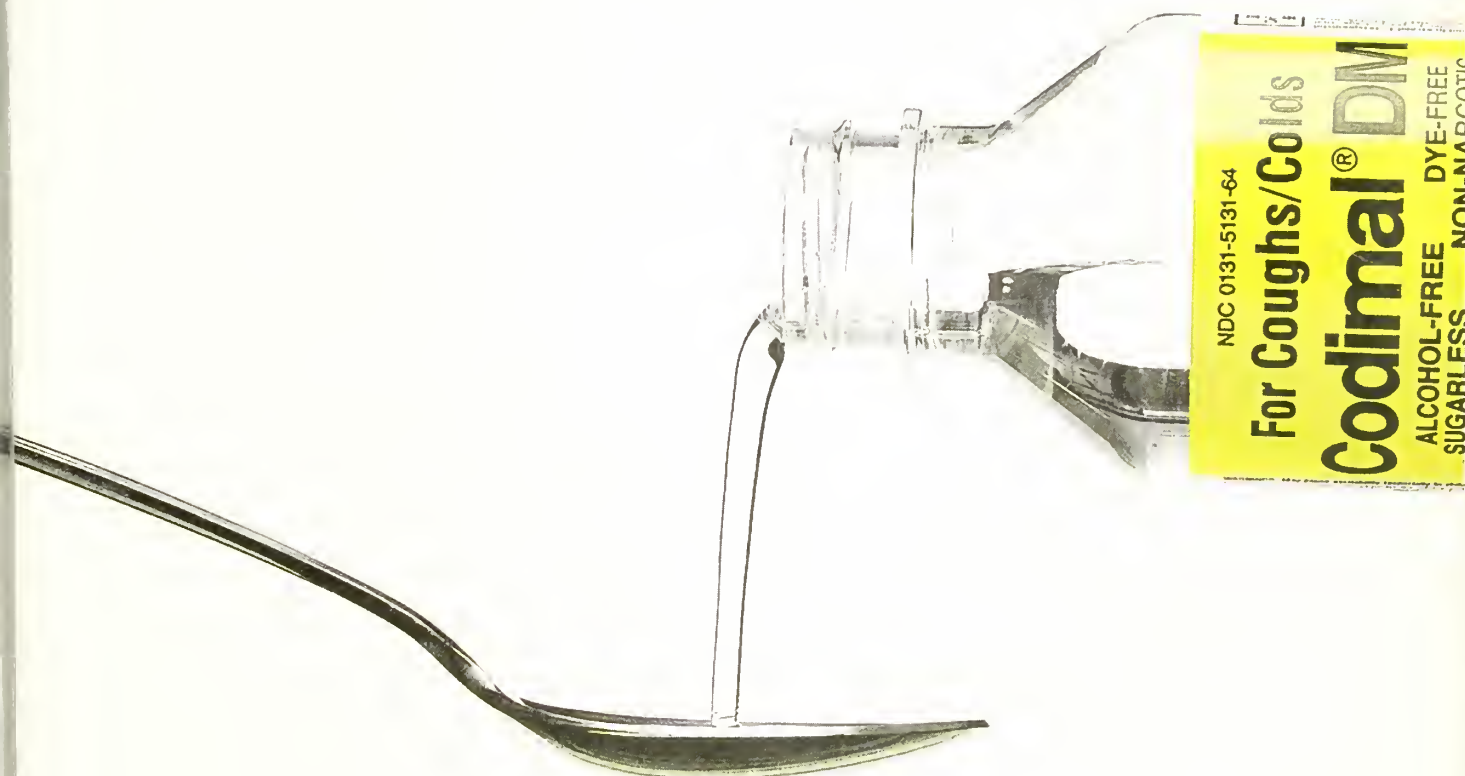
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Physician support needed for AMA Patient Protection Act

ISMA members are being asked to urge their legislators to support the AMA's Patient Protection Act. The legislation, introduced in the House of Representatives as HR 4527, would require insurance companies to give patients a full explanation of how their insurance plans' provisions affect them.

The act would assure the following: that patients and their physicians – not insurance companies – control the care patients get; that patients have a choice of physicians and health plans; that patients have information about what their plan covers, copayments and prior approval requirements; that no physician can be kicked out of a plan for giving patients the care they need; and that patients who choose a plan that restricts access to physicians may purchase a point-of-service option to see a physician outside of the plan.

ISMA membership survey to provide socioeconomic data

The ISMA is conducting a survey to gather more information about its members, their practices and their communities. The survey, called Strategic Health, will be mailed to all active members in July.

The survey will collect socioeconomic information on ISMA members and help physicians become better informed about the Indiana medical profession.

One survey response will be selected at random from the completed surveys at the end of the surveying period. The physician whose survey is selected will receive one year of ISMA dues free. All responses will be strictly confidential, and only aggregate responses will be reported. Results will be available to all ISMA members, county medical societies, specialty societies and state officials.

ISMA convention to look at health reform, technology

"Health Care 2000: What's Ahead in Reform and Technology" will be the focus of the ISMA's 145th Annual Convention and Exposition. Scheduled for Oct. 21 to 23 at the Westin Hotel in downtown Indianapolis, the convention will examine the latest political developments in health reform and demonstrate how new technology will impact physician practices in the future.

John Iglehart, the national correspondent for *The New England Journal of Medicine*, will explain the status of health system reform and forecast what's ahead during the morning program Oct. 22.

The annual IMPAC luncheon Oct. 22 will feature Charles Bierbauer, CNN senior Washington correspondent. After lunch, a panel of national and local experts will address the problem of family violence. Panelists will include Robert McAfee, M.D., AMA president; Anne Flitcraft, M.D., a national expert on family violence; Michelle Condon, M.D., an abuse victim; John Pless, M.D., an Indianapolis pathologist; and Laura Berry, executive director of the Indiana Coalition Against Domestic Violence. □



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Chicago will be the backdrop for this exciting program during the week of October 9-14. For a copy of the advance registration brochure for the Clinical Congress, please send in your request today. We hope to see you there!

Best personal regards,

Seymour I. Schwartz, MD, FACS
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■ letter to editor

Get basic

Let's face it. We are part of the problem. Every time we write a prescription, which costs the patient \$47, it is our fault. You do not find the parking lot at GE full of Mercedes, Lexus' and Lincolns, but you do at the doctors' parking lot at the hospital.

Not only that, but we are part of a special interest group, and there are only 350,000 non-federal practicing physicians – a pretty small number of votes in a nation of 265 million. Our patients may love us, but at any one time, only 15% of the nation are patients, and the rest of the people do not like doctors. These are the facts.

So forget our demands to the Congress for special privileges in the health care reform package, even if they are good for our patients. As far as Congress, labor and big business are concerned, we are pot-holes in the road to progress. The road needs to be patched but not at the cost of pampering us.

Granted, things are not good in the field of health care delivery. There is, however, one overriding issue, even though not only the president but the entire Congress is downplaying it over electioneering interests in universal coverage, employer mandates, malpractice reform, medical IRAs and a lot of other systems trivialities. That one overriding concern, the one thing that put the whole "reform" process into motion, is cost.

It is vital that we all communicate with our congresspersons. But do not push for pet reforms such as simplified paperwork; those are items not issues, and it is time to address issues. Do not even write as a physician; write as a citizen. Leave the M.D. or D.O. off the letterhead and out of the signature, and write.

The one big issue is money. That issue has two major subdivisions that have been the engines driving spending sky-high: the federal government and the commercial health insurance industry (including HMOs, PPOs, etc.), and they feed off each other. Neither the Congress nor the president really want to face this fact (even though Hillary, for personal reasons, hates the insurance industry). We have to shove it in front of their faces – now. Congress is hard at work on our future.

"Health care reform" is an unconscionable hoax. Saving money on health care always has been #1 on the agenda of the American voter. What the Congress is giving us is universal coverage and a well-hidden, ever-increasing price tag.

Paradoxically, we could have universal coverage and save \$300 billion to \$400 billion annually on health care now, without rationing, if Congress is really serious about doing the will of the people and willing to overturn some deeply entrenched preconceptions.

What follows is the bare framework for true health care reform, the details of which I will supply anyone, in or out of Congress, on request.

Congress owes it to the voters to take a harder look at the overall structure of the health care plans in those nations that have established successful universal medical coverage. I say successful because most of those nations have a level of care nearly as good as we now enjoy in the United States, but at a maximum cost of only 9% of their gross domestic product (GDP), compared to the 14% the United States spends today – before universalization. And 17% after cost savings, Hillary Clinton let slip recently.

The distinguishing feature of successful foreign systems is the almost total lack of government and insurance micromanagement of caregiving by professionals. To emulate those countries, Congress needs to give us a near total overhaul of the Health Care Financing Administration, parts of OSHA and of the Department of Justice – and of their regulatory structures. It also needs to change the commercial health insurance industry so that up front, published indemnifications for each specific service are mandated and to remove from it any leeway to approve or disapprove professional health care decisions. Managed care has long since been proven to be the engine driving a huge portion of the health system cost increase.* It takes dishonesty to deny it.

Write your senators and representative, and tell them you want them to save big bucks before they start "giving" us anything. ■

George C. Manning, M.D.
Fort Wayne, Ind.

*The fiscal basis for this statement is obscured by the internalization of the numbers into other statistics such as the federal budget and insurance company financial statements viewed over time. Oblique references include:

1. Executive salaries. *Business Week*, April 26, 1992.

2. Eiseman B: A new clause in the social contract. *Bull Am Col Surg*, 79:23-35, 1994.

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As national health care legislation takes shape in Washington, D.C., individual states are looking at health care reform on a state level. In Indiana, that effort is headed by Myra C. Selby, the governor's director of health care policy.

Ms. Selby accepted this position in August 1993. She had been a partner with the Indianapolis law firm of Ice Miller Donadio & Ryan, where she specialized in health care law, since 1983. Before that she focused on labor and employment law as an associate with a law firm in Washington, D.C.

She received her law degree in 1980 from the University of Michigan Law School, where she was also a research assistant and instructor.

She has written and co-authored numerous publications including *Hospital and Physician Liability: A Legal and Risk Management Overview and Risk Management Handbook for Health Care Facilities*. Ms. Selby is a member of the Indiana State Bar Association and is listed in *The Best Lawyers in America*. In 1990, she received the "A Breakthrough Woman" Award from the Coalition of 100 Black Women for being the first African-American woman to become a partner in a majority Indianapolis law firm. She serves on the boards of directors of several community organizations in Indianapolis.

In this conversation with INDIANA MEDICINE, Ms. Selby talks about her job, the governor's health care initiatives for Indiana, the role of state policy and national health care reform legislation and how physicians can be-

come personally involved in shaping health care policy in Indiana.

INDIANA MEDICINE: What are your duties as director of health care policy for Indiana?

Selby: I work with all areas within state government that have either health care programs or have health care responsibilities. That would include the Department of Insurance, the State Department of Health, Family and Social Services Administration (FSSA) and divisions within FSSA. I coordinate state health policy from the aspect of all of those agencies. I am also the governor's liaison with the Indiana delegation in Congress for federal health care policy issues, and in that respect, I work on state issues in national health care reform.

INDIANA MEDICINE: Would you consider your position as being more reactive or proactive?

Selby: Oh, I think there's always a bit of both. I think that it is proactive in the sense that there are many opportunities for states in health care reform. It is also necessarily reactive to the constant ebb and flow of what's going on in Washington and how that affects states. I think I am in both modes fairly consistently.

INDIANA MEDICINE: Will the governor develop a health system reform plan to present to the legislature?

Selby: If you're talking about a comprehensive plan of reform, in all likelihood that will not be the focus. Rather, the focus will be on addressing areas where state



be partners in reform

government and state programs can make a difference. I think that while the state shouldn't wait and let its fate be determined by Washington, at the same time, the state should carefully look at what is a state initiative and will remain a state concern. [This could include] such issues as dealing with the uninsured population and some other population-specific concerns that are within the jurisdiction of our state department of health. State government will also continue to be concerned about cost containment, not just [in response to] the all too familiar Medicaid budget pressures, but also about cost containment of health care expenditures in general. Irrespective of what legislation we get on the national level, states will have to move in the direction of supporting innovative concepts for allowing more people to purchase affordable health insurance through pooling mechanisms or by creating insurance programs at more affordable levels. These are all things that states can and should continue to do, and I would foresee some effort for us to look at these solutions.

[In Indiana, we have] an overall approach that would sharpen and heighten the role of state government where state government has an appropriate role. State government doesn't and shouldn't do everything in health reform. I think that's just as important as asking what state government is doing or is going to do.

INDIANA MEDICINE: Who is assisting you in developing health care reform in Indiana?

Selby: Primarily I rely on the

support of the various state agencies and organizations that have particular areas of expertise or responsibility. I don't have an infrastructure or staff to myself. I work with the State Department of Health, Insurance, FSSA and the State Budget Office in bringing about all of these things. I also work with non-governmental organizations like yours in their areas of expertise.

“
Irrespective of what legislation we get on the national level, states will have to move in the direction of supporting innovative concepts for allowing more people to purchase affordable health insurance through pooling mechanisms or by creating insurance programs at more affordable levels.
”

INDIANA MEDICINE: What other interested parties do you find yourself consulting with?

Selby: Certainly the ISMA is an important one. Some of the other organizations that I work with represent other providers – hospitals, HMOs, community mental health organizations and primary health care associations. Depending on what I might be doing, I also work with advocacy groups

of any type, form and shape. [I work with] just about everyone, I like to think.

INDIANA MEDICINE: What are you doing in the area of consensus-building?

Selby: I think that in order to accomplish objectives in the area of health care reform, it does have to rely on a consensus-building process. Everyone has something to say and has a feeling or a concern or an opinion. And everyone is just as important as the next one, so it is vitally important to rely on a consensus-building process.

INDIANA MEDICINE: Where would you say that whole process is right now?

Selby: We have just submitted an application for a state health reform grant to the Robert Wood Johnson Foundation, which has funded most state health reform initiatives that we read about today, in states like Oregon, Washington and Minnesota. We are hoping that the hypotheses that we are suggesting be tested in that grant will provide the kernel for the coalescing of the data collection and health reform analysis that would support change that makes good policy and economic sense. That would be an example of an initiative, although not a plan. The whole design [of the Robert Wood Johnson grant proposal] tests certain hypotheses to find out whether or not they hold water and whether or not they can be established or refuted.

INDIANA MEDICINE: On what aspect of Indiana health care policy

does it focus?

Selby: It's focused on several conditions and diseases and illnesses, which we characterize as chronic or critical. One of the hypotheses is that these conditions are the most costly conditions in the health care arena right now. The study would focus on whether or not that's true, first of all, and whether instead of the 17 or so conditions that are suggested to be the most costly, maybe there are 12, or 10 or 15. Following that analysis, there would be an exploration of whether or not it's feasible and economically advantageous to look at a different approach to insuring for the risk of those diseases. The thought is that if one is able to build in a higher level of predictability for those conditions or diseases, one might be able to exert downward pressure on the cost, the process of insuring for these diseases, as well as insuring generally. That's what the project is intended to test.

INDIANA MEDICINE: **How much guidance does the governor intend to give the legislature within the construct of this Robert Wood Johnson Foundation grant?**

Selby: At some point during the development phase of the project, we would begin the task of examining what sort of legislation [may be] necessary. Before that time, there would be legislative input solicited by us with respect to any issues requiring either legislative changes or new legislation. Our approach on this project is to make it intragovernmental from the very onset, so that we have

the state agencies involved supporting the project, working with legislative leadership and with the support of this office in a coordinating type of role. Our hope is for [legislation] to happen as the project proceeds and naturally evolves.

INDIANA MEDICINE: **So right now, you're basically involved in a process of finding out what part of health care in Indiana is broken and what's not?**

Selby: Right. Particularly in the area of health, in many cases we don't have data, or the data that we collect are not in a form readily available for analysis. So whatever we do, we have to make sure that we clearly state what our data needs are and how we can meet them, because that has to underlie anything that we would offer by way of legislation.

INDIANA MEDICINE: **How much do you think Congress will defer to the states with regard to health care reform?**

Selby: That remains to be seen. I think that there is a collective will on the part of Congress and on the part of President Clinton to allow the states the greatest flexibility that's possible, and I think that will remain a steadfast principle to which both the President and Congress will be committed. I think that's the clear signal coming from both Congress and the White House. How that actually gets translated from a state's perspective is often quite different than the intention of those who are crafting the federal legislative approach, but I think there'll be a great deal of flexibility for states

to continue to explore state actions and state reforms. I also think that given the administration's commitment to streamlining and expediting the waiver process for Medicaid programs, that you'll see a continuation of and accommodation of states' concerns and state experimentation.

If a state reform doesn't address the areas that Congress determines must be addressed, then I don't think that state's reform is something that one would say should remain untouched or unaffected by federal legislation. That's just not the way it works, particularly when the federal government is expending the major percentage of the dollars in total national health care expenditures. On the other hand, to the extent that state reforms are not inconsistent with and can coexist with a federal plan, there is every reason to believe that the signal from Washington is that states should proceed and continue to chart their course.

Meanwhile, state Medicaid budgets are growing by leaps and



bounds, so there really is not a valid reason to sit on one's hands and just wait. Things like Medicare and Medicaid are significant in this whole debate. There's no reason to think that the federal government will sustain 50 different approaches, all of which are inconsistent with what the federal government wants to see happen. On the other hand, I think that many of the plans that are being debated in Congress right now have taken all of that into account at the very beginning and built in a great deal of state flexibility.

INDIANA MEDICINE: What's your opinion on a single-payer system?

Selby: Like any other system approach, a single-payer system has its advantages and disadvantages. We know of single-payer systems that exist out there in the world, Canada being one example. Many would suggest Medicare in the United States is another example. I think that there are some good things about single-payer, and there are some things that aren't so good.

INDIANA MEDICINE: What are some good things?

Selby: Administrative ease, simplicity. I think the simplicity probably also leads to broader acceptance of the system itself, by consumers as well as probably by providers. I think some of the downsides are those that we hear all the time about the Canadian system – with access, with long waits, with some technology and some procedures not being available. Those are some of the real returns in a single-payer system

that I think Americans would need to face up to realistically in determining whether or not that's a viable approach. That's not to suggest that it is not, but I think that has to be considered when one examines a single-payer system.

INDIANA MEDICINE: What is your opinion on price controls?

Selby: I think the relative disadvantage, meaning that it perverts market forces, does apply to price controls no matter what you attach them to. The advantage, of course, is control of price. That's why I say in the abstract, I don't have a meaningful answer because I think that you would have

“
I would invite physicians in Indiana to be partners with the Bayh administration in achieving health care reform ...
”

to then attach it to something and say that you're willing to pervert the market in order to achieve the goal. I guess in health care, you could attach [price controls] to payment for services, for example. Some would argue that's exactly what we've seen in the Medicare and the Medicaid programs. Others would say no, it's controlling the cost. So it depends on whose perspective you take.

Let's take Medicare as an example. I think what has hap-

pened is the effort to exert some control on price has resulted in price being controlled for that payer, for the federal government. We also know that part of the result has been, because it was a control on price and not cost, that cost then gets shifted, so that where price is not controlled, namely for the other payers, they pay more. I don't think that's an optimum approach under anyone's analysis. Looking at health care reform in the broad and comprehensive way that we're doing now, maybe for the first time, we may have the will to address the inequity of programs that necessitate or support cost shifting. I think one has to be very careful if one's going to try to achieve price controls without having other, perhaps unintended, consequences.

INDIANA MEDICINE: Are there any states that in your opinion could be models for Indiana in health care reform?

Selby: Not any particular state. And the reason is you have to take the state as you find it. There is no other state that is Indiana in every respect, or even in the important respects. From the very beginning, the notion that we would pattern ourselves after another state simply will not work. You may find that we are very close in many ways to a lot of states in terms of the percentage of our population that's not insured or the percentage that have health coverage through their employer, for example. But I really do not think that's a useful analysis because the first difference you hit is probably going to be the biggest. What uninsured



folks do in Indiana for their health care compared to what uninsured folks do, for example, in Florida or Texas, is very different.

INDIANA MEDICINE: What is your message to physicians in Indiana about health care reform?

Selby: I would invite physicians in Indiana to be partners with the Bayh administration in achieving health care reform and achieving it in a way that makes sense for patients, for providers – including hospitals, doctors, clinics, health centers and all other kinds of entities – for payers, for business, for everyone. I say partners because, as I've said consistently, I don't think health care reform can be achieved in a meaningful and lasting way without all of those groups at the table. Physicians are included and in many, many, many minds, physicians are first.

INDIANA MEDICINE: How can physicians out there be partners with the governor?

Selby: I'll go back to this Robert Wood Johnson grant as an example. We would foresee the need for a great deal of participation by physicians both for clinical analysis and also for looking at physician and provider types of issues that you have whenever you're looking at diagnoses and costs and how you arrive at those two things. I think you make sure that the ISMA is participating in these efforts of the governor's office. If you as the individual doctor want to be that person on the clinical analysis support committee, then you make sure someone is aware of that. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

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Americans with Disabilities Act: Are you in compliance?

Bob Carlson
Indianapolis

Question: How do you know for sure that you're not in compliance with the Americans with Disabilities Act?

Answer: Somebody sues you. And wins.

That's the legal remedy available under the Americans with Disabilities Act (ADA) to disabled individuals who believe they have been discriminated against because of their disability. In terms of taxpayer dollars, it's a lot less expensive than having a big government bureaucracy monitoring millions of employers and public accommodations for compliance with the ADA.

In terms of what it could cost you as a defendant in such a suit, you can't afford not to be in compliance with the ADA. Especially when you consider that the ADA is one of the most reasonable and flexible civil rights laws ever enacted by Congress. In fact, once you understand how the ADA works, you'll probably wonder what all the fuss is about. It's basically just good business policy and common sense, codified and signed into law by President Bush on July 26, 1990.

Disability broadly defined

"The ADA applies to two parts of your practice. First, to your employees. Secondly, to the physical structure of your office and the building it's in, and to your policies in dealing with patients," says Kevin Betz, an attorney with the Indianapolis law firm of Krieg

DeVault Alexander & Capehart. He specializes in employment law and the ADA.

It's important to understand how broadly the ADA defines an individual with a disability. It's not only someone in a wheelchair. Under the ADA, a disabled person is someone who:

1. has a physical or mental impairment that substantially limits that person in a major life activity;
2. has a record of such a physical impairment; or
3. is regarded as having such an impairment.

Physical and mental impairments include, but are not limited to, contagious and noncontagious diseases and conditions such as tuberculosis, HIV infection, cancer, alcoholism and drug addiction, and orthopedic, visual, speech and hearing impairments. The phrase physical and mental impairments does not include homosexuality or bisexuality. The term disability does not include transvestism, pedophilia, kleptomania or compulsive gambling.

Major life activities are functions such as caring for oneself, performing manual tasks, seeing, speaking, breathing and working.

The three-part definition makes it illegal to discriminate against:

1. a person with a disability – someone who has an actual physical or mental impairment – not simply a condition such as hair or eye color, left-handedness, or advanced age; or
2. a person with a record of impairment – such as a person

with a history of cancer or mental illness – who no longer has the disease but is discriminated against because of his or her record of impairment; or

3. a person who is regarded as having an impairment – such as a person with a visible scar which does not actually limit the person in any major life activity, but the person is nonetheless discriminated against because of the scar.

The above definitions are taken from a 10-page American Medical Association publication entitled *The Americans with Disabilities Act: A Prescription for Compliance*. Attorney Betz recommends this publication as an excellent introduction to the ADA for physicians. He has also written his own, somewhat more detailed, questions-and-answers overview entitled *A General Overview of the Americans with Disabilities Act of 1990*. It is available from Krieg DeVault Alexander & Capehart.

The first step in complying with the ADA, says Betz, is to become sensitive to the intent of the ADA, which is to eliminate discrimination against the 46 million Americans with disabilities. "Once you're sensitive, the rest takes care of itself, because the rest is common sense."

If you're an employer

If you're an employer with 25 or more employees, the ADA became effective July 26, 1992. For employers with 15 to 24 employees, it becomes effective July 26, 1994. If you employ fewer than 15

workers, you are not covered by the employment requirements of the ADA.

The employment provisions of the ADA are administered and enforced by the Equal Employment Opportunity Commission (EEOC), the same federal agency that handles complaints about race and sex discrimination.

"When it comes to the employer requirements for the ADA, you can get stung a little bit harder [than for non-compliance with the requirements for public accommodations]," cautions Betz. "In the employment sphere, plaintiffs can get punitive damages, they can get all kinds of compensatory costs. It's likely to be more of a battle."

Here's how to stay out of trouble with the ADA if you're an employer. Again, the touchstone is sensitivity to individuals with disabilities and common sense.

First, you do not have to give preference to a person with a disability in your hiring decision. You should select the most qualified applicant, without regard to the existence or consequence of a disability. If that applicant happens to be disabled, that means you must focus on the applicant's ability to perform the "essential functions" of the job with a "reasonable accommodation."

A job description may seem like a pretty straightforward description of duties and responsibilities. But if you have an applicant who is a "qualified individual with a disability," your current job description, job advertisements and employment tests could get you into trouble with the ADA unless they focus on the "essential functions" of the job. For example, your job description

Sources for more information

More information on the Americans with Disabilities Act is available from the following sources:

NATIONAL

American Medical Association
1-800-AMA-3211

Department of Justice
ADA Information Hotline
(202) 514-0301

Job Accommodation Network
1-800-526-7234

Equal Employment Opportunity Commission
1-800-669-3362

National Rehabilitation Hospital
ADA Health Care Facility Access Project
(202) 877-1974

National Center on Accessibility
1-800-424-1877

Great Lakes Disability and Business Technical Assistance Center
1-800-949-4ADA

INDIANA

ADA Training Network
1-800-484-4167 (access code 5450)
(317) 541-0834

ATTAIN (Accessing Technology Through Awareness in Indiana)
1-800-545-7763
(317) 232-1203

Governor's Planning Council for People with Disabilities
(317) 232-7770

Equal Employment Opportunity Commission
(317) 226-7212

Job Accommodation Network
Allen County League for the Blind
(219) 745-5491 □

for a transcriptionist may include wording such as "read physician notes and keystroke into computerized patient chart." The essential function would be "enter physician notes into computer," rather than "read physician notes." A qualified transcriptionist who is visually impaired could do that if the physician notes were tape recorded.

In this example, taperecording your notes instead of writing them would be the "reasonable accommodation" that would enable a qualified applicant with a disability to perform this essential job function. Other reasonable accommodations might include making existing facilities readily accessible and usable by an individual with a disability; restructuring a job; modifying work schedules; or acquiring or modifying equipment. An often-used example is elevating a desk or other surface so that an individual in a wheelchair can work there.

"You don't have to give them a 24-carat gold computer," says Betz, "but only something that's reasonable, given the means and operations of your workplace. An important part of the process is talking with that person and saying, 'do you think this will work,' keeping things very open and having a give and take dialogue going on."

A "reasonable accommodation" for one employer may be an "undue hardship" for another. An undue hardship is defined as "an action requiring a significant difficulty or expense when considered in light of the nature and cost of the accommodation in relation to the size, resources, nature and structure of the employer's operation."



Larry Carter, M.D., attends a medical education program at Ball Memorial Hospital in Muncie. As a result of the ADA, a special area was built in the back of the hospital's auditorium to accommodate wheelchairs. (Ball Hospital photo by Rick DeCroes).

But cost is not the only basis on which an employer may be able to show undue hardship. An employer could show that a particular accommodation would be unduly disruptive to its other workers or have a negative effect on customers. In summary, accommodations and any expenses associated with making those accommodations are considered on a case-by-case basis.

While the ADA in general is very much oriented to case-by-case evaluation, evidence of a desire to make accommodations, and mutually satisfactory arrange-

ments worked out between employer and employee, it expressly defines several types of prohibited discrimination. For example, as an employer, you may not ask whether a prospective employee is disabled. You may not use testing that has the effect of discriminating on the basis of an individual's disability. You may use a post-job offer medical examination as a requirement for employment, but only if the exam is required of all entering employees in the same job category regardless of disability.

As an employer, you should

remember that being sensitive to job applicants with disabilities entails more than just *feeling* sensitive. You also need to translate that sensitivity into appropriate language. "If a deaf person applies for the receptionist job, do not ask 'how are you going to do this job and be deaf?' Do not ask that," cautions Betz. Rather, ask the applicant how he or she can perform job functions that seem difficult or impossible because of the disability, and whether an accommodation would be needed. Discussing the ADA requirements with your attorney in advance can prepare you to deal with this kind of employment situation and comply with both the letter and the spirit of the law. Indeed, you may end up with a terrific receptionist who reads lips so well that his or her hearing impairment turns out to be a non-issue.

Doctors must comply

Here is how the AMA defines "public accommodation" in *The Americans with Disabilities Act: A Prescription for Compliance*:

"All physicians must comply with Title III of the ADA concerning services provided by public accommodations. Under the ADA, the term public accommodation encompasses all private businesses that offer goods and services to the public. Consequently, the ADA's access requirements for public accommodations apply to virtually all businesses, including hospitals, clinics and physician offices.

Under this provision of the ADA, it is illegal to discriminate against a person with a disability in the 'full and equal enjoyment of the goods, services, facilities, privileges, advantages or accom-

modations of any place of public accommodation.' What does this mean? It means that all businesses and service providers (from theaters and restaurants to libraries and physicians) must take steps to make their facilities and services accessible to individuals with disabilities."

Some examples of modifications to accommodate an individual with a disability are installing ramps; making curb cuts; rearranging furniture; widening door openings; modifying restrooms; or adding Braille markings to elevator controls. In the language of the ADA, these modifications must be "readily achievable."

Again, what is readily achievable for one business may not be for another. In deciding what is readily achievable in a specific case, the ADA cites several factors to be considered:

- the nature and cost of the action;
- the financial resources;
- the party involved;
- the financial resources of related entities; and
- the impact of the action on the operation of the business.

"The one golden rule of the ADA as far as physical structures and policies," says Betz "is to make sure the person with the disability has [physical] access to your product or your services."

The next priority would be to provide access to those areas where the services are made available, followed by access to restroom facilities and, finally, to take any remaining measures required to remove barriers.

This does not necessarily mean spending money on physical modifications like tearing out your old doorway and putting in

a wider door with an electric door opener. For some physicians, compliance with the ADA's public accommodations requirements might mean that a disabled patient calls ahead, is met at a certain entrance at a prearranged time and helped into the office and exam room.

"That's not the most recommended method of doing it," says Betz, "but if you're small enough and your resources are small enough, that would be complying within reason. Now if you're Methodist Hospital, that would be *per se* a violation of the ADA. This is all measured by the resources available. That can make the ADA confusing, but at the same time, it makes it very commonsensical."

The ADA is equally commonsensical about eligibility criteria used by public accommodations to determine who may receive service. For example, if you require a driver's license for identification when someone pays you by check, and that's all your front office people will accept, that would constitute discrimination against patients who can't get a driver's license because they are visually impaired.

"Auxiliary aids and services" may be required to communicate effectively with your patients. For example, some disabled patients may need help in disrobing or dressing, or hearing impaired patients may require a qualified interpreter. The ADA regulations are flexible and encourage consultation with disabled individuals in choosing among various alternative auxiliary aids or services.

Legal remedies available for individuals who believe they have been discriminated against by a

public accommodation because of their disability include bringing suit against the public accommodation. Disabled persons may even sue a business based on the belief that discrimination *is about to occur*. They may also file complaints with the U.S. Attorney General, who may bring suit in cases of general public importance or where a "pattern or practice" of discrimination is alleged. In these cases, the U.S. Attorney General may seek monetary damages, civil penalties, attorney fees and costs.

Costs and benefits

If you're an employer, making "reasonable accommodations" for a qualified employee with a disability to do the job may not entail any out-of-pocket expense if all that's required is restructuring a job or modifying work schedules. In his question-and-answer brochure about the ADA, Betz writes "workplace experts estimate that 80% of these accommodations should cost less than \$500."

In any event, remember that you are required to make only "reasonable" accommodations, and that the definition of reasonable does take into account factors such as the action necessary to achieve compliance, the financial resources of your business and the impact the action would have on your business.

On the upside, in addition to gaining a qualified employee, you may be eligible for a Targeted Job Tax Credit, which allows a credit of 40% of a disabled employee's first-year pay, up to \$6,000.

Your expenses in complying with the ADA's public accommodations requirements will depend on the physical access changes required to make your office and building accessible to patients with disabilities and on the auxiliary aids and services required to effectively communicate with your patients. However, those changes must be "readily achievable" for your business; the auxiliary aids and services may not impose an "undue burden" on your practice; and you are not required to do anything that would fundamentally alter the nature of your services.

If you lease office space, your landlord would generally be responsible for changes in common areas and for policies, practices or procedures applicable to all tenants. As a tenant, you would

facilities, that may be necessary to comply with ADA requirements. Those changes may include widening doorways or installing elevators, new restrooms, ramps, electric door openers or appropriate signage. Then again, depending on your individual circumstances, none of those changes may be necessary.

Architects and architectural engineers conduct ADA audits. Other businesses, known as code consultants, specialize in ADA audits. The cost for an ADA audit can vary widely, depending on who does it and on the size of your office or clinic. Don Able, AIA, vice president and partner with the Indianapolis architectural firm Able Ringham Moak Park, estimates \$1 per square foot for a relatively small office of 1,500 square feet, but adds, "That is a

very loose estimate. A lot of issues could change that drastically, depending on how much needs to be documented, the time involved, and the end product you might want." Able says his firm's

hourly rates range from \$50 an hour for a staff person to \$100 per hour for a principal of the firm.

K.C. Cohen of React, Inc., an ADA compliance firm in Fishers, says his firm's estimates are also based on square footage. "Generally speaking, for a doctor's office with a waiting area, two or three patient rooms, some operating space, a reception counter and a file room, you're under a thousand bucks. Well under a thousand bucks." Cohen says that also includes generating a report on

After consulting with your attorney about your responsibilities under the ADA, you should arrange to have an ADA audit conducted of your place of business.

generally be responsible for changes, auxiliary aids and policies in your leased space.

After consulting with your attorney about your responsibilities under the ADA, you should arrange to have an ADA audit conducted of your place of business. An ADA audit – which is sometimes also referred to as an ADA compliance study, an ADA barrier survey or an ADA assessment – identifies any changes in the physical layout of your office, your building, even your parking

the results of the survey, going through the report with the client and devising a reasonable remediation plan.

If structural changes are indicated in your ADA remediation plan, that means getting bids from contractors and additional expense for the actual construction work. Keep in mind that like any law, and perhaps more than most, the ADA is subject to interpretation. Without competent counsel and an ADA remediation plan, you may spend money on unnecessary changes or neglect required changes. A company that combines ADA auditing services, remediation planning and construction contracting may have a vested interest in recommending structural changes that require construction work.

Tax benefits are available to help pay for the cost of ADC compliance. Your business may be eligible for a deduction of up to \$15,000 for expenses associated with the removal of qualified architectural and transportation barriers. Under the Disabled Access Tax Credit, eligible small businesses (gross receipts under \$1,000,000 and work force less than 30 full-time employees) may also receive a tax credit for certain costs of compliance with the ADA.

Advocacy groups for the disabled point out that there is one more benefit to complying with the ADA: revenue. Like other consumers, disabled individuals spend their money where they are made to feel welcome.

What you should do now

"I think you should go to your lawyer first. That's a typical lawyer's answer," admits lawyer

Betz, "but let's put this in the proper perspective. We're not dealing here with social service standards. We're not dealing with architectural standards. We're dealing with civil rights law here. We're dealing with the rights of individuals to be treated fairly in the workplace and in public accommodations, within reason. What does 'within reason' mean? That's what lawyers do best, is help sort these questions out."

"It's a law and your first step ought to be to talk to your legal counsel about the ramifications of the ADA for you," says architect Able. "As a physician running a practice, you're also an employer, and you have to have standards in place for hiring and accommodating employees that could be disabled."

Douglas W. Reddington, AIA, associate principal with BSA Design, agrees that lawyers play a key role in achieving ADA compliance. "In fact," he says, "many of the seminars to educate us about the ADA are put on by lawyers." BSA design is an Indianapolis architectural firm specializing in health care facilities.

In addition to the AMA's *The Americans with Disabilities Act: A Prescription for Compliance*, and similar materials available from your attorney, there are hotlines, newsletters and other publications from a variety of sources to help you and your staff come up to speed on the ADA (see page 277). Federal, state and local government agencies; private not-for-profit organizations; and advocacy groups are other sources of help and information.

"You'd be amazed how well these groups are attuned to the

ADA," says Joe Mrak, head of the architecture department at Reid, Quebe, Allison, Wilcox & Associates, consulting engineers and architects in Indianapolis. "You will find, though, that different groups have different requirements," he cautioned, citing the case of the small dome-shaped bumps specified for curb cuts in the original ADA *Accessibility Guidelines*. The bumps were supposed to alert the visually impaired that they were about to step into the street, but wheelchair users found the bumps to be hazardous to wheelchair traffic. According to Mrak, the case is being litigated.

The human dimension

"We always think about disabilities in terms of wheelchairs and those kinds of things. We need to think about it more broadly to include those who are visually or hearing impaired," said Michael Seidle, M.D., director of Student Health Services at Ball State University in Muncie and medical director of a facility for the developmentally disabled and two nursing homes.

Dr. Seidle has multiple sclerosis and uses a wheelchair. "My disabilities have caused me to be much more sensitive about this than I once was. And I say that with embarrassment." He suggested that physicians may want to invite patients with handicaps to evaluate their office.

His personal pet peeve, from one physician to another?

"One thing physicians do is stand up and talk to people. If you're in a wheelchair, you really get kinks in your neck. You really do. That's not how most of us would like to be communicated

with, whether we're in a wheelchair or not."

Larry Carter, M.D., is a board certified family physician and associate director of Family Practice Residency at Ball Hospital in Muncie. He has multiple sclerosis and gets around in an electric cart and a specially equipped van. "I think it wouldn't be a bad idea to just have everybody get in a wheelchair and try to get a drink at a water fountain, get lunch and go to the bathroom," he suggested with a chuckle.

What does Dr. Carter think of

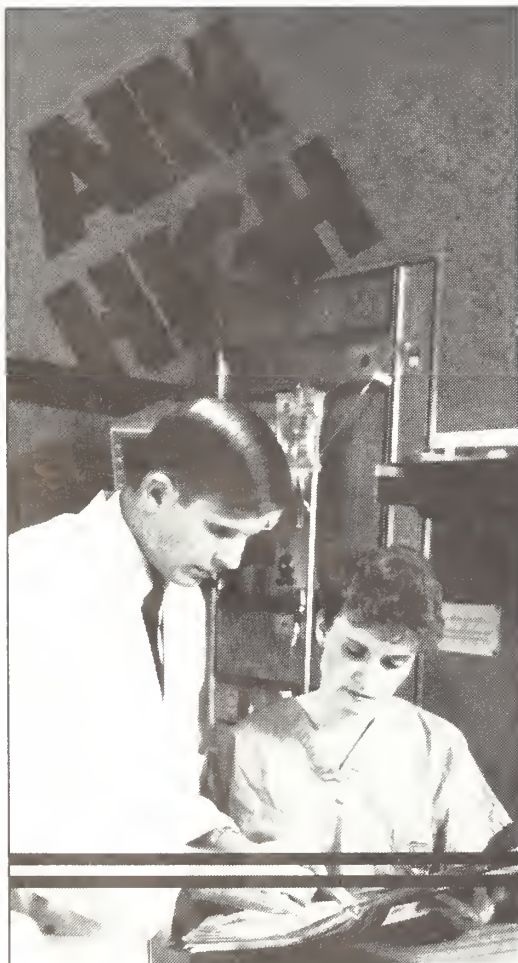
the ADA?

While he has some reservations about the practicality of bringing suit as a legal remedy, he says, "The authors of the ADA should really feel kind of good about getting the ball rolling. It won't be the total answer to all of the hazards the physically challenged have to meet, but it certainly is a good start."

To illustrate his point, Dr. Carter shared some anecdotes about water fountains that dribble water down his shirt, ramps that are too steep, lack of automatic

door openers and parking spaces designated for the handicapped that aren't wide enough. He also recalled an incident in New York City where there was a curb cut on one side of the street but not on the other. Fortunately, several people asked if they could help. "We can make a lot of stuff," observed Dr. Carter, "but it really is going to be people that make the law work." □

The author is a health care communications consultant in Indianapolis.



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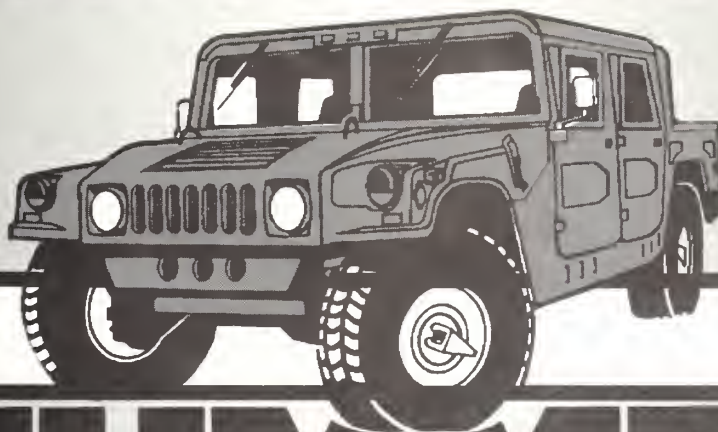
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The 10 most important clauses in a managed care contract

Nathan R. Mowery
Indianapolis

Here it is on the table in front of you. Another managed care contract. What should you do? Sign it and send it back? Or should you skim through it to satisfy that uneasy feeling that you should have at least looked at it before signing? Or do you or an adviser carefully review all of its terms to ensure that you know what it says and how it will impact your practice? Do you find yourself somewhere in between?

Physicians in Indiana have sometimes taken a casual approach to contracting. After all, in a state where every physician has signed up for just about every insurance plan, network and program available, what incentive is there to pore over every word of every contract? What difference could a few words here or a few terms there make?

The statewide growth of managed care with capitated reimbursement, risk pools, withholds and risk shifting will change all of that. As physicians begin to assume more financial risk for the care of their patients under capitated arrangements, their contracts with managed care organizations (MCOs) take on much greater importance. Physicians must treat these contracts as assets of their practices and afford them the attention and care they would any other practice asset.

The following checklist gives physicians a basic framework for evaluating their managed care contracts. It does not cover precontracting issues nor does it purport to be a complete treatise on what belongs in a managed care contract. Rather, it serves as a starting point for physicians to more effectively evaluate, and more importantly, to effectively negotiate managed care contracts.

	Yes	No	N/A
1. Parties to the Contract			
a. Is the party asking the physician to sign the contract merely a broker for other MCOs and not an MCO itself?	—	—	—
i. If yes, does the broker have the authority to bind such MCOs?	—	—	—
ii. Are the MCOs represented by the broker bound to the terms of the contract as if they were signing it?	—	—	—
b. Is the physician signing the contract as a representative of the group rather than in his/her personal capacity?	—	—	—
c. If the group adds a physician in the future, is that physician covered by the contract?	—	—	—
2. Compensation			
a. Does the contract clearly state the method of compensation?	—	—	—
i. If based on fee for service or discounted fee for service, is a schedule of the rates attached?	—	—	—
ii. Are the rates acceptable?	—	—	—
iii. If based on full or partial capitation, is the capitation rate adequate?	—	—	—
(A) Has the MCO provided the physician with utilization statistics concerning age, income and other demographic factors of the MCO's enrollees?	—	—	—
(B) Does the physician know the likely			

level of utilization by the MCO's enrollees?	Yes	No	N/A
(C) Is the volume of the MCO's enrollees sufficient to warrant the physician's involvement?	—	—	—
(D) Is there stop-loss protection in the contract? Is it adequate to cover the risks of adverse selection?	—	—	—
(E) Has the physician evaluated the role and impact of risk pools, withholds or similar arrangements?	—	—	—
(F) Has the physician been provided with a detailed history of past distributions from risk pools?	—	—	—
(G) Has the physician evaluated his/her level of exposure beyond the risk pools if utilization for the MCO's entire plan exceeds budget?	—	—	—
b. How and when will the physician be paid?	—	—	—
i. Are there adequate assurances for the prompt payment of fees?	—	—	—
ii. Is there a penalty for late payment of fees?	—	—	—
iii. Is payment measured from the date of submitting a clean claim rather than the date of approval of the claim?	—	—	—
iv. Is "clean claim" defined satisfactorily?	—	—	—

v. Is there a fixed time frame for challenging a physician's bill and is it reasonable?	Yes	No	N/A
vi. Is there an effective protocol for verification of coverage?	—	—	—
vii. Is payment guaranteed as long as the physician follows the rules regarding verification?	—	—	—
viii. Can the physician pursue a patient for payment if the MCO fails to pay?	—	—	—
ix. Has an effective protocol been established for the physician to follow upon the denial of a claim?	—	—	—

3. Term

a. Is the term of the contract certain?	—	—	—
b. Would a short, one-year "trial" term make sense if this is a new MCO with no track record?	—	—	—
c. Does the contract have a self-renewal clause?	—	—	—
i. If so, is the contract clear regarding when to give notice of intent not to renew?	—	—	—
ii. Is there a provision for automatic annual renegotiation of the payment rates well in advance of the date for giving notice of intent not to renew?	—	—	—
d. Does the physician have a consolidated internal calendar to track contract terminations, renewals or renegotiation dates?	—	—	—

4. Termination	Yes	No	N/A
a. Are the MCO's reasons for terminating the contract clearly stated?	___	___	___
i. Are the reasons reasonable?	___	___	___
ii. Are the reasons based on clear, objective criteria?	___	___	___
b. Are the physician's reasons for terminating the contract clearly stated?	___	___	___
i. Are the reasons reasonable?	___	___	___
ii. Are the reasons based on clear, objective criteria?	___	___	___
c. Is notice of default required to be given by the non-defaulting party?	___	___	___
d. Is there a reasonable cure period which allows for the correction of the default?	___	___	___
e. Is there an effective dispute resolution mechanism such as mediation or arbitration?	___	___	___
f. Does the contract remain in effect after termination for settling outstanding accounts?	___	___	___
g. Does the MCO promise to pay the physician for services rendered to covered enrollees seen up to the date of the termination?	___	___	___
5. Physician Responsibilities			
a. Is the physician promising to follow all policies, procedures and protocols of MCO?	___	___	___
i. Has the physician obtained and reviewed them? (i.e. utilization review and quality assurance plans, operating manuals, administrative guidelines, etc.)?	___	___	___
ii. Are these reasonable?	___	___	___

	Yes	No	N/A
b. Must the physician accept all covered enrollees?	___	___	___
i. Can the physician close his/her practice to new covered enrollees and, if so, under what conditions?	___	___	___
ii. Can the physician refuse to see a "problem patient"?	___	___	___
c. Is the physician responsible for coordination of benefits (COB)?	___	___	___
i. Are COB priorities established?	___	___	___
ii. Does the physician have the right to seek assignments from enrollees for COB purposes?	___	___	___
d. Is the physician free to enroll in other MCO plans and networks?	___	___	___
6. Access to and Disclosure of Records			
a. Does the contract reflect the physician as owner of medical records?	___	___	___
b. Is the MCO obligated to obtain a valid release of medical records from its enrollees?	___	___	___
c. Is the MCO obligated to adhere to all applicable laws with respect to patient confidentiality and medical records release?	___	___	___
d. Is the MCO obligated to pay copying costs of the records requested?	___	___	___
7. Insurance, Indemnification			
a. Are the types and policy limits of insurance required by the MCO consistent with the physician's present coverage?	___	___	___
b. Is the MCO required to carry adequate policies of insurance as well?	___	___	___

	Yes	No	N/A
c. Does the MCO's insurance cover exposure arising from utilization and quality review activities?	—	—	—
d. Do indemnification provisions run to the benefit of both parties?	—	—	—
e. Is the duty to indemnify limited by provider's applicable insurance coverage?	—	—	—
f. Does the indemnification protection extend to agents and employees of physicians?	—	—	—
8. Definitions			
a. Is "medical necessity" defined specifically enough to protect the physician?	—	—	—
i. Are there grievance and appeal procedures for determinations of medical necessity by the MCO that are adverse to the physician?	—	—	—
b. Is "covered services" defined broadly enough to encompass all services provided by physician?	—	—	—
c. Is "emergency services" defined broadly enough to protect the physician?	—	—	—
9. Insolvency Protection			
a. Is the MCO required to provide financial statements within 120 days of the end of its fiscal year?	—	—	—
b. Is the MCO required to give notice of deficiencies in its reserves?	—	—	—
c. Is the MCO reinsured, and has proof of reinsurance been provided?	—	—	—
d. Can the physician "bail out" if the MCO fails to comply with insolvency protection clauses?	—	—	—

	Yes	No	N/A
10. Miscellaneous			
a. Does an amendment to the contract require the physician's specific written agreement?	—	—	—
b. Is there a statement that the parties are independent contractors and that the physician can render all medical services based on his/her independent professional judgment?	—	—	—
c. Does the physician have some control of the use of his/her name in marketing materials?	—	—	—
d. Does the MCO agree to be bound by all applicable federal, state and local laws, rules, regulations and statutes?	—	—	—
e. Can the contract be renegotiated if there is a change in laws that materially affects reimbursement?	—	—	—
f. Can the physician have a first right of refusal if the MCO adds new services or develops a new product?	—	—	—

The next time you receive a managed care contract for your signature, take the time to closely review it first. This checklist is a good starting point. Ask questions and don't be afraid to request that changes be made. You will never know unless you ask. Know what you are signing. The health of your practice depends on it. □

The author is an attorney with the Indianapolis law firm of Krieg DeVault Alexander & Capelhart and represents physicians and other health care providers as part of the firm's health care practice group.

The material in this article is provided for general information and should not be understood as legal advice concerning any particular information.

Managed competition means more group physician practices

Thomas C. Erickson
Kameron H. McQuay
Indianapolis

Marcus Welby's practice has been closed forever. The era of the solo physician is gone, and we are about to enter the age of the large, multi-specialty physician group practice.

Is this just another faux prediction? Not when the demands for reform, recent events in Indianapolis and the examples set in other areas of the country are understood.

The fundamental issue behind health care reform plans is control of the rapidly escalating cost of the health care delivery system. The cost of providing our high-tech/high-touch, acute-care-based health care is going up at a rate that cannot be tolerated. If major reforms are not made, health care costs will rise to \$1.74 trillion by the year 2000, an increase of 131% over 1991.

Hillary Rodham Clinton and business leaders are looking at the lessons learned in more advanced and competitive markets like Minneapolis. Their conclusion is that managed competition is the most acceptable and proven way to control costs while maintaining current levels of quality.

While Clinton's plan seems to be foundering in turbulent waters, businesses are accomplishing significant changes of their own. Managed competition is already

gaining momentum in Indianapolis. As payers leverage their buying power, hospitals re-trench and physicians consolidate, the delivery system will change dramatically in response.

The demands made by managed competition can be distilled to three points:

- lower cost;
- equal or better quality of care; and
- health care providers assuming financial risk for treatment decisions.

A solo physician or small group of single-specialty physicians simply will not have the

physicians practice medicine and how well they practice business.

While bigger is not necessarily better, the lessons from around the country are clear. Physicians in group practices have the resources to coordinate care and demonstrate to payers that they can provide quality care at low cost. Group practices that focus on quality improvement and protocol development can gain a competitive edge over groups that do not invest in those systems.

However, as groups increase in size, the business risks increase proportionately, and internal controls often clash with profes-

sional ethics and physicians' desire for autonomy. Consequently, managing group practices is a great challenge.

From the physician's perspective, many

who work in multi-specialty group practices believe they are able to practice better medicine because of the setting and are more satisfied with their working conditions. In a multi-specialty group, physicians can develop consultation teams and close working relationships among specialist, primary care and ancillary providers that bring high-quality care to patients at affordable cost.

Is the growth of group practices inevitable? Probably.

Comparing Indiana with Minnesota, Indiana has 1.2 million more residents, 1,150 fewer physicians and significantly smaller physician group practices. In Minnesota, 40 physician group

The fundamental issue behind health care reform plans is control of the rapidly escalating cost of the health care delivery system.

resources to meet these demands. Physicians will be forced by the market to join larger organizations with the resources to compete under the new mandates.

Is forcing physicians to join larger groups bad? Not necessarily. It all depends on the group the physician decides to join and how the physicians, as colleagues, choose to work together. In a group practice, there are many issues such as income distribution, work assignment, expansion, investment and health plan participation. Each of these issues, and others, must be resolved fairly and equitably within the group. The success of a group practice hinges directly upon how well the

practices have more than 25 physicians each; 18 of those have more than 50 physicians; and seven have more than 200 physicians (the Mayo Clinic alone has 1,200 physicians in Rochester, Minn.).

By contrast, in Indiana, 16 physician group practices have more than 25 physicians; five of those have 50 or more physicians; and none has more than 200 physicians. In fact, the largest group practice in the state is in Lafayette, with 108 full-time-equivalent physicians.

The trend toward larger

groups is already manifesting itself in Indianapolis. Hospitals are aggressively buying primary care physician practices. In the past 15 months, more than 200 pediatricians, family physicians and internists have sold their practices to local hospitals. Specialty groups are likewise adding primary care physicians to their groups, and there have been unprecedented mergers among physician practices.

The result of all this restructuring will be that the face of physician practices will change dramatically. Those physicians who take

the challenge early will have a better chance of working out the problems that come with a larger group practice and likely will have a greater chance of success under managed competition. □

Erickson is a senior consultant in the health care services division of Blue & Co. McQuay is a manager and director of physician services with the company.

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Digest of health and medical laws

1994 Indiana General Assembly

Cooperation and compromise were evident throughout the 1994 session of the Indiana General Assembly. In this pre-election year, lawmakers went out of their way to find middle ground on issues of hot discussion before the legislature. Even the news media remarked on the "brotherly love" between Democrats and Republicans in the Statehouse. But, while cooperation was such a buzzword during this year's short session, notably absent among the issues debated were any major health system reform bills. Legislators instead worked on less entangled areas of health care and medicine and watched Washington. Next year, in the long session, we are much more likely to see serious discussion of health system reform.

While health system reform was not first on the minds of legislators this year, our lawmakers were far from idle. Members of the General Assembly introduced 863 bills this year, and after the dust from the political process had cleared and all the legislators had gone home, 176 made their way to the governor's desk to become law. The governor also was cooperative this year. He did not veto a single bill given to him for approval by the legislature.

This *Digest of Health and Medical Laws* is designed to familiarize you with changes in state policies that will impact you and your patients. This document is not intended to provide details of the new laws regarding health and medicine, but it will serve as a useful overview of the 1994 session. For additional information about any of the statutes or proposals summarized in this booklet, call the ISMA Government Relations staff at 1-800-257-4762 or (317) 261-2060.

Michael D. Abrams
Director of Government Relations

Louis M. Belch
Assistant Director of Government Relations

Katherine A. Vaughn
Legislative Liaison

Deborah E. Warner
Administrative Assistant

Robin C. Koch
Legislative Intern

Senate enrolled acts

All new laws are effective July 1, 1994, unless otherwise noted.

SEA 49

- Authors: Weatherwax, Hunt
- Sponsors: Dvorak, M. Smith
- Requires the department of insurance to make available to the public information concerning the Indiana long-term care program, long-term care insurance policies, Medicare supplement policies, Parts A and B of the Medicare program, prepaid health care delivery plans and the Medicaid program;
- requires an insurer who issues a qualified long-term care policy to at least offer each policyholder or prospective policyholder a policy that provides both long-term care facility coverage and home and community care coverage; and
- allows an insurer who offers such a policy to also offer a policy that provides only long-term care facility coverage.
- Effective upon passage.

SEA 99

- Authors: Kenley, K. Smith, Riegsecker, Simpson
- Sponsors: Brown, J. Lutz, Grubb, Kruse
- Creates the central repository for controlled substances data;
- requires a patient to present identification when presenting a prescription for a controlled substance;
- requires pharmacies to transmit to the central repository information regarding prescriptions for controlled substances;
- sets requirements for the release of information from the central repository;
- allows the pharmacy board to define a prescription; and
- prohibits the pharmacy board from requiring multiple copy prescriptions.
- Effective upon passage.

SEA 204

- Authors: Miller, Craycraft, K. Smith, Breau
- Sponsors: Crosby, Wenger, Barnes, Munson
- Provides that a child born with any amount of a controlled substance or a legend drug in the child's body shall be eligible for the Child in Need of Services Program (CHINS). Makes an exception if the drug detected in the child's body was a legend drug or a controlled substance for which the child's mother had a valid prescription during pregnancy if the mother made a good faith attempt to use the legend drug or controlled substance according to the prescription instructions.

SEA 367

- Authors: Landske, McCarty, O'Day, Mrvan
- Sponsors: Dvorak, Fesko, Wenger
- Requires that a practitioner who is convicted of insurance fraud be reported to the appropriate licensing board.

SEA 375

- Authors: Miller, G. Howard
- Sponsors: Crawford, Schmid, Barnes
- Allows a provider to disclose to another provider or to a non-profit medical research organization a health record to be used in connection with a joint scientific, statistical or educational project; and
- requires confidentiality of the health records to be protected and states that the patient's identity may not be disclosed. A person who recklessly violates or fails to comply with this requirement commits a Class C infraction. Each day a violation continues constitutes a separate offense.

SEA 430

- Authors: Rogers, Leising, Riegsecker, Wyss
- Sponsors: V. Smith, Engle
- Requires the state board of education to adopt rules further defining the nature and extent of participation and otherwise regarding the implementation of the additional pupil count (for funding purposes) for students with chronic attention deficit disorder (ADD). The initial year for additional funding under this program is the 2002-2003 school year.
- requires the department to conduct a study of the funding and delivery of services to students with chronic ADD and to report these findings to the legislature before Jan. 1, 1999.
- Effective July 1, 2001.

House enrolled acts

All new laws are effective July 1, 1994, unless otherwise noted.

HEA 1013

- Authors: Wenger, Kearns
- Sponsor: Worman
- Requires an insurer to include on each identification card and on all benefit books that are delivered to an enrollee whose policy requires a utilization review determination a printed statement that reads substantially as follows: "NOTICE: Pre-certification or pre-authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed."
- Effective on all identification cards and benefit booklets printed after Jan. 1, 1995. Insurers are not required before Dec. 31, 1997, to issue new identification cards and benefit booklets that include the

printed statement to enrollees for whom the insurer provides coverage on Dec. 31, 1994.

HEA 1023

- Authors: Crawford, Porter
- Sponsors: Miller, K. Smith
- Requires not-for-profit hospitals to report to the state department of health the amount of charity care given.

HEA 1037

- Authors: R. Hayes, Bayliff, Brown, V. Smith
- Sponsors: Landske, McCarty, Gery, Miller, Lubbers, Alexa, K. Smith
- Allows a person to make a declaration in a living will regarding the provision of artificially supplied nutrition and hydration;
- the living will only applies when the person is in a terminal condition; and
- living wills that were drafted before July 1, 1994, containing provisions regarding nutrition and hydration are valid.

HEA 1059

- Authors: Gulling, Sturtz
- Sponsor: Meeks
- Requires people confined to a county jail to make a copayment of up to \$10 for each provision of medical, dental, eye care or other health care-related service;
- the person is not required to make this copayment if he does not have funds in his commissary account at the time of the service or within 30 days after the service is provided. No copayment can be required if the service is provided in an emergency, as a result of an injury received in the jail or at the request of the sheriff or jail administrator; and
- money collected must be deposited into the county medical care for inmates fund.

HEA 1076

- Authors: Ruppel, Cook, Willing, Porter
- Sponsors: Riegsecker, Zakas, Alexa, Antich
- Requires county law enforcement agencies to provide to each law enforcement officer employed by the county continuing education concerning response to Sudden Infant Death Syndrome (SIDS). Agencies also may provide this education to law enforcement officers employed by cities and towns within the county; and
- full-time and volunteer firefighters and emergency medical technicians must complete a basic or in-service course of education on SIDS.

HEA 1078

- Authors: Day, Bayliff, Avery, Warner
- Sponsors: Johnson, Gery
- Removes the expiration date from the local health

maintenance fund, making the duration of the fund's existence unlimited.

HEA 1081

- Author: Alevizos
- Sponsor: Riegsecker
- Limits information that may be requested by an insurance company from a patient's mental health record;
- limits the charge for copying medical records to 25 cents per page;
- allows a \$15 retrieval fee for copying the medical record. If the retrieval fee is charged, the first 10 pages must be provided free of charge; and
- allows an additional \$10 charge for requests that must be processed in 48 hours.

HEA 1113

- Authors: Kromkowski, Brown
- Sponsors: Miller, Mrvan, Landske, K. Smith
- Requires a hospital with at least 100 beds to have a physician on duty at all times; and
- requires the state department of health to promulgate rules to ensure continuous coverage for in-patient emergencies.

HEA 1119

- Authors: Scholer, Klinker, Pool, Brown
- Sponsors: Harrison, Gery, Miller, Wolf
- Allows Tippecanoe County to consolidate its health departments;
- allows the state department of health to authorize expert review panels to provide confidential consultation and advice to health care workers who are infected with the human immunodeficiency virus (HIV) or who are infected with the hepatitis-B virus (HBV) and are hepatitis-B antigen (HBsAg) positive; and
- grants civil immunity to a member or a member of the staff of an authorized expert review panel for activities conducted in good faith in the scope of the panel's duties.

HEA 1257

- Authors: Fry, Linder
- Sponsors: Mills, McCarty, K. Smith
- Allows a PPO to offer gatekeeper plans if certain conditions are met;
- requires that the gatekeeper be a physician; and
- exempts certain specialties from the gatekeeper requirement, including anesthesia, ophthalmology, dermatology and outpatient psychiatric services.
- Effective upon passage.

HEA 1298

- Authors: Bauer, Lytle, Cochran
- Sponsors: Harrison, McCarty
- Modifies the Medicaid fraud statute to allow the attorney general, rather than the county prosecu-

tor, to file fraud charges in court. This section is effective July 1, 1994; and

- requires Medicaid to pay, deny or suspend a claim within 30 days. If the claim is denied or suspended, the office shall notify the provider of each reason for the action. This section is effective Nov. 1, 1994.

HEA 1299

- Authors: Bauer, Turpin, Porter, Kearns
- Sponsors: Borst, Gery
- Exempts the sale of a non-legend drug from the state gross retail tax if the drug is dispensed upon an original prescription or drug order for a person confined to a hospital or health care facility; and
- exempts the sale of food from the state gross retail tax if the food is prescribed as medically necessary by a physician.

HEA 1316

- Authors: Dvorak, Linder, Gulling
- Sponsor: Miller
- Requires state certification of dietitians.

HEA 1321

- Authors: Brown, Budak
- Sponsors: Miller, Breaux, Lewis, Paul
- Requires every notification of a medical claims review determination to include a concise explanation of the rationale for the determination. A medical claims review determination is a determination of the appropriateness of the charges for medical services;
- the explanation must include information about any and all data bases that are used in the determination;
- if a data base is used, there must be information regarding the items in the data base. Specifically, if the information is based on amounts charged for health care services outside Indiana; and
- if the review determination uses a percentile limit, that limit must be included in the explanation.

HEA 1323

- Author: Brown
- Sponsors: Miller, Breaux, Riegsecker
- Requires any contractor or vendor of the state responsible for providing or managing any part of the Medicaid outpatient drug program to submit an annual report including a description of the nature and scope of the prospective drug utilization review (DUR) program; and
- allows the chairman of the DUR board, with the approval of the board members, to appoint an advisory committee to make recommendations to the board on the development of a Medicaid outpatient drug formulary. If the office decides to establish a Medicaid drug formulary, the formulary shall be developed by the DUR board.
- Effective upon passage.

HEA 1327

- Authors: V. Smith, Klinker, Becker
- Sponsors: Bray, Doll, Randolph
- For licensure purposes, requires a hospital to demonstrate that it has established procedures to reduce the likelihood of abduction of newborn babies and other infants from the hospital. These procedures may include controlling access to areas of infant care, video camera observation of areas of infant care and identification of hospital staff and visitors; and
- for licensure purposes, a hospital also must establish procedures to aid in the identification of newborns and other infants. These procedures may include footprinting, photographing, maintaining written descriptions of infants and obtaining and recording cord blood samples at the time of an infant's birth for the purpose of conducting genetic testing.

HEA 1376

- Authors: Crosby, Bayliff, Goeglein, Brown
- Sponsors: Miller, Breaux, K. Smith, Riegsecker
- Restructures the public mental health system;
- requires the division of mental health to provide long-term in-patient mental health beds in the area of the state that used to be served by Central State Hospital;
- requires actuarial studies to be conducted of the mental health delivery system; and
- creates the Indiana Commission on Mental Health.

HEA 1412

- Authors: Villalpando, Bayliff, Henderson
- Sponsors: Wyss, Alexa, Bray
- Allows the court to order the suspension of a minor's driver's license for up to one year if the minor is found to possess, consume or transport (without being accompanied by the minor's parent or guardian) an alcoholic beverage. If the minor is less than 18 years of age, the suspension shall be for at least 60 days;
- makes it a Class D felony for a person operating a motor vehicle to cause serious bodily injury to another person if the person is found to have at least 0.10% blood alcohol content (BAC) and a Schedule I or II controlled substance in the person's blood or if the person is intoxicated. The person commits a Class C felony if the person causes the death of another person;
- makes it a Class B infraction for the driver of a motor vehicle to knowingly allow an open alcoholic container to be in the passenger area of the vehicle if the driver has above 0.04% BAC; and
- makes it a Class B infraction to consume an alcoholic beverage while operating a motor vehicle.

1994 legislative morgue

The following is a partial list of bills that did not pass during this year's legislative session.

Senate Bill 2

- Authors: Wyss, Alexa, Landske, Sinks
- Digest: Sought to provide that a person who is less than 21 years of age and operates a vehicle with more than 0.01% blood alcohol content commits a Class C infraction. In addition, required the court to recommend the suspension of the person's driving privileges for at least 30 days but not more than one year.

Senate Bill 106

- Authors: Thompson, Wyss, R. Young, Antich
- Digest: Would have granted physicians immunity from civil liability arising from a prescription for a legend drug written by an optometrist and filled without the physician's oral or written authorization.

Senate Bill 143

- Author: Skillman
- Digest: Sought to prohibit children under the age of 18 from riding in the open bed of a truck. Makes the violation a Class C infraction.

Senate Bill 162

- Authors: Meeks, Smith
- Digest: Would have allowed an insurer to establish a preferred provider network with primary care case management. Would have repealed the "any willing provider" statute, allowing an insurer to discriminate among providers based on price, quality, patient access, services rendered and utilization.

Senate Bill 168

- Author: Miller
- Digest: Sought to prohibit smoking in buildings that contain areas available to the general public or that serve as a place of work.

Senate Bill 253

- Author: Meeks
- Digest: Would have allowed an employer to establish an employee medical care savings account (MSA). The employer could deposit in the MSA annually an amount of money less than or equal to the employee's deductible. The employee also could deposit money in the MSA, but the yearly total in the account could not exceed the amount of the deductible. Withdrawals from the MSA would be tax-exempt if they were used to pay for medical expenses.

Senate Bill 271

- Authors: Wyss, Simpson
- Digest: Sought to make it a Class A misdemeanor for a person to knowingly or recklessly leave a firearm where a child under the age of 18 might gain access to the firearm.

House Bill 1030

- Author: Howard
- Digest: Sought to prohibit smoking on school property. Would have made the violation a Class C infraction.

House Bill 1072

- Author: Crawford
- Digest: Would have taken part of the proceeds from the cigarette tax and applied it to the establishment of community health centers fund and the medical student tuition abatement fund.

House Bill 1141

- Authors: Wilson, Henderson, Cottey, Munson
- Digest: Sought to require a person to undergo testing for HIV and hepatitis B if the person is charged with an offense against an officer and the offense may have transmitted the HIV virus to the officer.

House Bill 1322

- Author: Brown
- Digest: Sought to require a health insurance company to accept and reimburse any health care provider who meets educational, monetary and contractual requirements. Would have required a hearing for a health care provider whose payment claim was denied.

House Bill 1324

- Author: Brown
- Digest: Would have created a health finance study commission.

House Bill 1326

- Author: Hays
- Digest: Sought to establish the Indiana Hospital Cost Containment Study Commission.

House Bill 1366

- Author: Grubb
- Digest: Would have made it a Class C felony for a person who has HIV to knowingly engage in high-risk activities with another person without first informing the person of the HIV-positive status.

Index

Those bills marked with an asterisk (*) were not successful during the 1994 session of the Indiana General Assembly. Summaries of these bills can be found in the legislative morgue.

- Alcohol
 - Consumption by drivers HEA 1412
 - Possession HEA 1412
 - Zero tolerance SB 2*
 - Multiple offenses HEA 1412
 - Open container HEA 1412
- Attention Deficit Disorder (ADD)
 - School funding for students with ADDSEA 430
- Children
 - Children in Need of Services (CHINS)SEA 204
 - Children in truckbeds SB 143*
 - Firearms SB 271*
 - Hospital identification, safety of newborns HEA 1327
 - School funding for students with ADDSEA 430
 - Sudden Infant Death Syndrome (SIDS) HEA 1076
- Cigarettes
 - see also Smoking
 - School property, on HB 1030*
 - Tax HB 1072*
- Community health centers HB 1072*
- Controlled substances
 - see Drugs
- Dietitians, certification of HEA 1316
- Drugs, illegal
 - CHINS eligibilitySEA 204
- Drugs, prescription
 - Drug Utilization Review (DUR) Board ... HEA 1323
 - Electronic Data Transfer ProgramSEA 99
 - Tax-exempt status, non-legend drugs HEA 1299
- Drunk driving
 - see Alcohol
- Firearms SB 271*
- Health departments, local
 - Tippecanoe County HEA 1119
- Health department, state
 - Expert review panels HEA 1119
- Health Finance Commission HB 1324*
- Hepatitis-B virus (HBV)
 - Expert review panels for health care workers with HBV HEA 1119
 - Mandatory testing HB 1141*
- Hospitals
 - Charity care HEA 1023
 - Cost containment commission HB 1326*
 - Doctor on duty HEA 1113
 - Hospital identification, safety of newborns HEA 1327
- Human Immunodeficiency Virus (HIV)
 - Expert review panels for health care workers with HIV HEA 1119
 - Mandatory disclosure HB 1366*
 - Mandatory testing HB 1141*
- Immunity, civil
 - Physicians, for prescriptions written by an optometrist SB 106*
- Insurance
 - FraudSEA 367
 - Gatekeeper plans HEA 1257
 - Long-term careSEA 49
 - Medical care savings accounts SB 253*
 - Medical claims review HEA 1321
 - Precertification notification HEA 1013
 - Any willing provider statute Preferred Provider Organizations SB 162* Strengthening of HB 1322*
- Jail inmates' health care HEA 1059
- Living wills HEA 1037
- Local health maintenance fund HEA 1078
- Medicaid
 - Drug Utilization Review (DUR) Board ... HEA 1323
 - Fraud HEA 1298
 - Provider antihassle HEA 1298
- Medical records
 - Disclosure for researchSEA 375
 - Duplication HEA 1081
 - Release to insurers HEA 1081
- Medical students
 - Tuition Abatement Fund HB 1072*
- Mental Health
 - Delivery system, restructuring of HEA 1376
 - Records disclosure HEA 1081
- Safety, public
 - Children in truckbeds SB 143*
- Smoking
 - Ban in public places SB 168*
- Sudden Infant Death Syndrome (SIDS) HEA 1076
- Tobacco
 - see Cigarettes, Smoking

Avoiding the 10% early retirement penalty

Joel M. Blau, CFP
AMA Investment Advisers, Inc.

As a rule, distributions from qualified plans are subject to a 10% penalty tax if they are withdrawn before the participant reaches age 59 1/2, becomes disabled or dies. The term "qualified plan" includes pensions, profit sharing plans, SEPs, Keoghs, IRAs and 403(b) annuities. Additionally, withdrawals are also subject to ordinary income taxation, which reduces your premature distribution even further.

When the age 59 1/2 rule was enacted, a general assumption was made that a "normal" retirement age would minimally be age 60, but times have changed. Corporate downsizing has forced many to begin retirement in their mid 50s. Many physicians looking toward health care reform may want to consider retirement before age 59 1/2. But how can

they access their retirement funds without paying the 10% penalty?

Several possible exceptions to the penalty rule exist, depending on your situation or need of the funds. If the objective is simply early retirement, the IRS will waive the 10% penalty if the distribution is part of a scheduled series of substantially equal payments. There are three different approved methods when calculating the distribution.

The first and most common is the single or joint life expectancy method. With this method, payments can be spread over the number of years set forth in the IRS tables based on a single life or joint life, which includes your named beneficiary.

The amortization method is a payment method similar to the annual amount required to pay off a loan at a reasonable interest rate over your life expectancy.

The third option is the annuity method. With this method, an

annuity factor must be determined from a reasonable mortality table using a given interest rate assumption. Once you begin annual distributions, you must continue them until age 59 1/2 or five years, whichever is later. Under this rule, a 55-year-old may receive fixed annual distributions to age 60. He then can stop the fixed amount and remove as little or as much as needed from the qualified plan at his discretion.

Even though all three seem similar, they yield different required annual distributions. If you are considering the substantially equal payments exception, your accountant should determine each method's result to match your income needs and avoid additional income taxation. □

The author welcomes readers' questions and can be reached at 1-800-262-3863.

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Wishard plaque honors pioneer hip surgeon

Clyde B. Kernek, M.D.
Indianapolis

Palmer Eicher, M.D., a pioneer in reconstructive hip surgery, has been honored with a commemorative plaque at Wishard Memorial Hospital in Indianapolis. The plaque includes the following text, written by Alfred B. Swanson, M.D.

"The Eicher Hip Implant – in this hospital on June 14, 1950, Palmer Eicher, M.D., pioneer hip surgeon, implanted his intramedullary stemmed replacement for the head and neck of the femur in his patient, Mrs. Sophia T. Hill. The Eicher hip was designed in cooperation with Zimmer, Inc., beginning in July 1949 at Warsaw, Ind. The Eicher prosthetic hip design was the forerunner of the femoral component of the universally used total hip reconstruction."



Dr. Eicher

Palmer O. Eicher, M.D., was born in 1904 in Berne, Ind. He received his medical degree at the Indiana University School of Medicine in 1932 and completed his internship at the Indianapolis City Hospital. He was in general practice until he joined the Army Medical Corps in World War II, when he became interested in orthopaedic surgery.¹

After the war, Dr. Eicher completed his orthopaedic surgery residency with Dr. Earl McBride in Oklahoma City. While there, he worked with Dr. McBride on the door knob hip prosthesis, which had a threaded intramedullary stem.

In 1948, Dr. Eicher moved to Indianapolis to practice orthopaedic surgery. He joined the Department of Orthopaedic Surgery at the Indiana University School of Medicine as volunteer faculty. He continued his studies on hip replacement and developed his concept of a smooth, intramedullary stem with femoral neck calcar collar. Zimmer Inc. made the Eicher hip implant in 1949.

Dr. Eicher and an orthopaedic resident, Wallace Miller, M.D., performed the first hip implant June 14, 1950, at the Indianapolis General Hospital, now known as Wishard Memorial Hospital.

Alfred Swanson, M.D., then an orthopaedic resident, assisted Dr. Eicher on his second case. Because of Dr. Swanson's personal interest in this historic event, he wrote a historical perspective on the femoral head intramedullary stemmed implant. Dr. Swanson has documented that Dr. Eicher inserted the first smooth,



The Eicher hip implant

intramedullary stemmed femoral implant with a calcar collar on June 14, 1950. Dr. Moore and Dr. Thompson first used their hip implants in 1951.²

The Eicher commemorative plaque is on display at Wishard Memorial Hospital. Dr. Eicher was a pioneer in the development of the intramedullary stemmed femoral head implant, a historically significant concept that was

the forerunner of the current design of hip replacements. □

Correspondence: Clyde B. Kernek, M.D., Department of Orthopaedic Surgery, University

Hospital, Room 1250, 550 N. University Blvd., Indianapolis, IN 46202-5255.

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A survey of mycobacteriology laboratory practice in Indiana

O.M. Aszkenasy, MFPHM,
MRCP, MB
Mary Ann Sprauer Abrams, M.D.,
M.P.H.
Mike Karlix, M.S.
Mary Marrs, R.N.

Tuberculosis (TB) remains an important public health problem in Indiana. The steady decline in reported new cases ended in 1989 (*Figure*), reflecting what has happened in the United States as a whole since 1984. Nationally, if the decline in the incidence of TB had continued unabated, there would have been 51,700 fewer cases than there actually were during the period 1985 to 1992.¹ New problems in prevention and control of the disease have emerged. Human immunodeficiency virus (HIV) infection is a risk factor for the development of TB. Seven percent to 10% of HIV-infected persons who have latent TB infection will develop active TB each year.² As the number of people with acquired immune deficiency syndrome (AIDS) in Indiana has increased,³ so has the proportion of TB cases among people with AIDS, although the absolute number remains low.

Drug-resistant TB has become a serious national concern. In a nationwide survey conducted by the Centers for Disease Control and Prevention (CDC) of new TB cases in the first three months of 1991, 14.4% of those tested had organisms resistant to at least one

anti-tuberculosis drug, and 3.3% had organisms resistant to isoniazid and rifampin.⁴ In the three-year period from 1989 to 1991, there were 20 cases of single drug resistance and seven cases of multi-drug resistance in Indiana.

The top priority of the Indiana TB Control Program is to render people with infectious TB non-infectious as soon as possible. Mycobacteriology laboratories play a key role in this process. They are responsible for the detection and isolation of mycobacteria, species identification and determination of drug susceptibilities. These studies should be performed only in laboratories whose workload and quality assurance are adequate to maintain the expertise required for clinical mycobacteriology.⁵

The purpose of this survey was to provide an overview of current practice in Indiana laboratories that undertake clinical mycobacteriology work. The study was prompted by anecdotal evidence obtained by the Indiana State Department of Health Mycobacteriology Laboratory that currently available laboratory techniques to rapidly identify multidrug-resistant TB are not universally applied and that reporting mechanisms of results to attending physicians may be inadequate.

Materials and methods

Laboratories undertaking clinical mycobacteriology work in Indiana

were identified from a list obtained from the College of American Pathologists. A standardized questionnaire was sent to the supervisor of each laboratory. This requested information about workload, laboratory techniques used by that institution or the one to which specimens are referred and mechanisms used to ensure physicians receive results.

Thirty-five clinical mycobacteriology laboratories were identified. Thirty-four (97%) responses were received. The major results of the survey apply to the laboratories themselves or those to which they refer specimens for further investigation.

Volume – The CDC recommends that laboratories undertaking clinical mycobacteriology work should receive a minimum of 40 specimens per month to maintain proficiency.⁶ Fourteen (41.2%) laboratories indicated they receive 40 or more specimens per month. Six (17.6%) receive fewer than 10 specimens per month.

Identification of mycobacteria – All mycobacteriology specimens should be cultured.⁴ Microscopy alone will detect mycobacteria in only a proportion of specimens that are subsequently found to be culture-positive.^{4,6} One laboratory (3%) indicated it did not inoculate all its mycobacteriology specimens to media for culture.

Since the 1940s, mycobacteriology investigators have reported that more acid-fast positive

smears are found by fluorescence than by bright field microscopy.⁷⁻⁹ Seventeen (50%) laboratories indicated they did not use a fluorescent microscopy technique for the examination of smears for acid-fast bacilli.

Traditional biochemical identification of *M. tuberculosis* requires about four weeks to complete. Six (17.6%) laboratories indicated they use biochemical methods to identify mycobacteria. Genetic probes are now available that can identify *M. tuberculosis* in about two hours.

Radiometric culturing of specimens is used by only five (14.6%) laboratories. *M. tuberculosis* grows at a faster rate in a liquid medium. Another advantage of using radiometric culturing is that liquid media can be used directly for genetic probing.

Drug susceptibility testing – As part of the strategy to combat the emergence of multi-drug resistant TB, the CDC recommends that all initial positive mycobacteriology specimens be tested for drug susceptibility.¹⁰ Nine (26%) laboratories do not routinely test initial cultures for drug susceptibility. Patients remaining culture-positive after three months of therapy should have susceptibilities repeated. Twenty-two (65%) laboratories do not routinely repeat drug susceptibility testing in this situation.

Drug susceptibility testing using antibiotic discs in 7H10 media requires three weeks of incubation before completion. Twenty-seven (79.4%) laboratories reported using this method. Susceptibility testing using the radiometric method requires one week for completion. Only seven (20.6%) laboratories indicated they use this method.

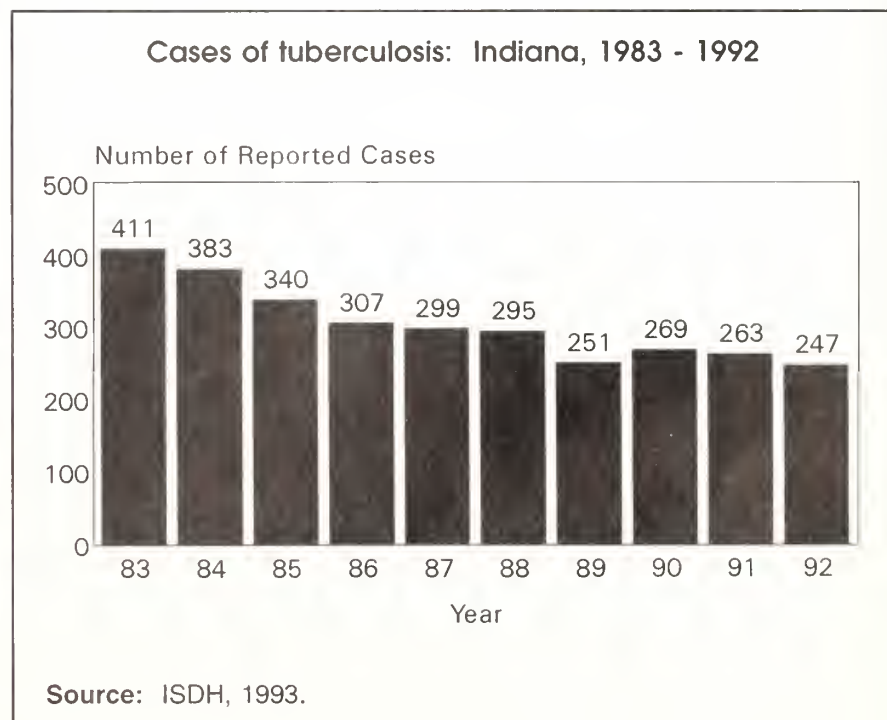
Reporting – Rapid identifica-

tion of *M. tuberculosis* is essential if control measures are to be applied in a timely and effective manner. Laboratories that use state-of-the-art technology are able to provide physicians with a preliminary report indicating the identification of *M. tuberculosis* in less than two weeks after receiving a specimen and a final report including drug susceptibility in less than six weeks. Thirty-three (97%) laboratories take longer than two weeks to generate an initial report of isolation and identification of *M. tuberculosis*, with a median of four to six weeks. Seventeen (50%) laboratories take longer than six weeks to generate a final report of isolation, identification and drug susceptibility testing, with a median of six to eight weeks.

Laboratories should ensure that physicians receive notification of results as soon as possible, particularly when a patient has drug-resistant TB. Twenty (59%) laboratories rely exclusively on the postal service; the rest telephone the result to the attending physician.

Discussion

This survey suggests that processing of mycobacteriology specimens in Indiana is suboptimal in a number of ways. A substantial proportion of laboratories are not receiving an adequate number of specimens to maintain proficiency in mycobacteriologic techniques. Many use out-of-date technology and procedures that are both inefficient and insensitive when compared to more modern techniques.



Figure

Table

Mycobacteriology laboratory techniques

Acid-fast microscopy techniques for smear examination

1. Ziehl-Neelsen - not recommended
2. Kinyoun - not recommended
3. Fluorochrome - recommended

Identification methods for *M. tuberculosis*

1. Biochemical - not recommended
2. DNA probes - recommended
3. High-performance liquid chromatography- recommended

Culture methods

1. Lowenstein-Jensen
2. 7H10
3. Radiometric - highly recommended, use a backup media such as Lowenstein-Jensen or 7H10

Drug susceptibility testing for *M. tuberculosis*

1. 7H10 agar plates - not recommended
2. Radiometric - recommended

Routine drug susceptibility testing for initial specimens is far from universal. More surprisingly still, for those specimens that remain culture-positive after three months, routine drug susceptibility testing is the exception rather than the norm. Clearly, specimens submitted to many of Indiana's laboratories will need careful follow-up by the attending physician to ensure that appropriate drug susceptibility testing is done at an early stage in the course of a patient's treatment. To ensure appropriate intervention, patients, contacts and health care providers need rapid laboratory response, particularly in the case of multi-drug resistant TB. Exclusive reliance on the postal service for reporting results is clearly inadequate.

The attending physician should ensure that specimens for mycobacterial analysis are sent only to laboratories that are able to maintain a high standard of

proficiency in processing mycobacteriology specimens. Physicians must be aware of advances in laboratory mycobacteriology to appraise the service being provided for them and their patients (Table).

The wide range of quality of service provided by mycobacteriology laboratories in Indiana suggests the need for centralization of this vital public health service. This would allow laboratories to receive an adequate volume of specimens with which to maintain expertise and facilitate monitoring of standards. A likely consequence of such a policy would be an improvement in the epidemiologic surveillance of multi-drug resistant TB in Indiana. □

Dr. Aszkenasy and Dr. Abrams were affiliated with the Indiana State Department of Health at the time the survey was conducted. Dr. Aszkenasy is now a consultant in

public health medicine with Tees Health Joint Administration in Cleveland, England. Dr. Abrams is now at St. Vincent Hospital in Indianapolis. Karlis is supervisor of the mycobacteriology lab at the ISDH, and Ms. Marrs is former director of the Tuberculosis Section, Communicable Disease Division, at the ISDH.

The authors thank Mary Ann Zupan and Cheryl A. Million for administrative support.

Correspondence: O.M. Aszkenasy, MB, TH Poole Hospital, Nunthorpe, Middlesbrough, Cleveland TS70NJ, England.

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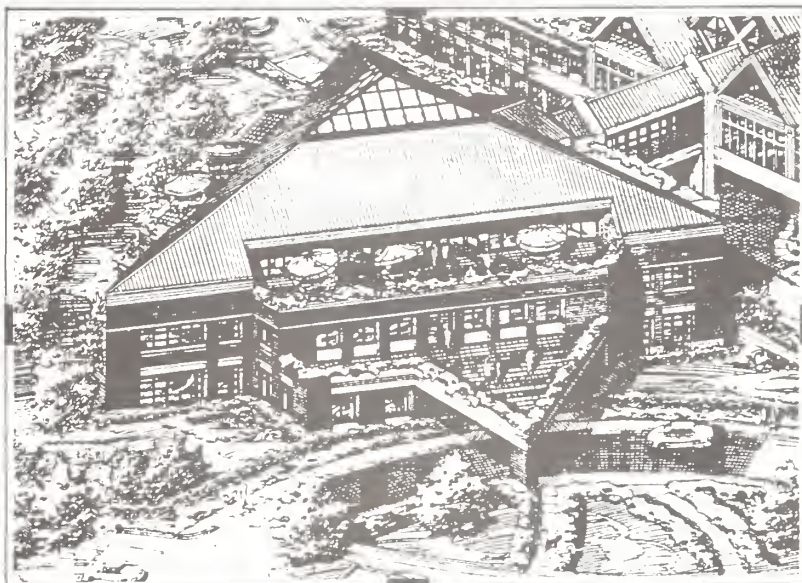
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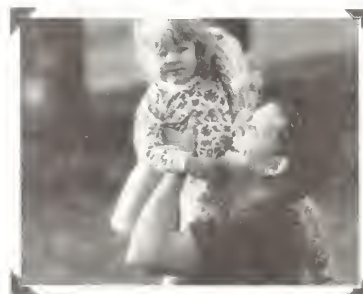
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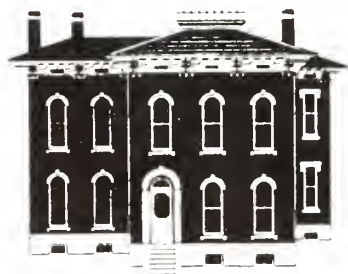


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Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Managed Health Plans and the corporate affiliate of Arnett Pharmacy.

Practice Setting

At this time, over 110 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

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Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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Lafayette, Indiana

■alliance report

Alliance adopts bylaws revision at convention

Sue Ellen Greenlee, ISMA
Alliance president
Lucy Reed Foltyniak,
corresponding secretary

The Noble-LaGrange County Alliance was the host for the 50th and last alliance convention in its current format. In keeping with the tradition of having its annual meeting during April in the home area of the current state president, the convention was held at Amish Acres in Nappanee in northern Indiana. Sue Ellen Greenlee, the current president, is from Kendallville in Noble County.

Eating disorders, AIDS and the adoption of revised bylaws were among topics discussed.

Speakers on eating disorders were Irene Celcer, M.S.W., and Shelli Yoder, Miss Indiana 1992, who spoke about her own struggle with anorexia/bulimia. The AIDS program included a talk by Maribeth Ransel, M.A., a Department of Education consultant on AIDS in Indiana, and a presentation on AIDS by Straightway, a teen drama group.

The bylaws revisions now enable the Alliance to elect officers, conduct business and hold the yearly convention with its partner, the ISMA, in the fall in Indianapolis. The current officers will serve an 18-month term.

Members enjoyed the Amish Acres Threshers dinner, musical entertainment, buggy rides and farm tours.

Dues increase approved

Delegates voted at the convention to increase the dues from \$18 to \$25, effective with the billing mailed in the fall of 1995. Because of increasing costs of postage, printing, seminars, speakers and the annual convention, delegates decided more revenue is required to keep the alliance functioning and progressing. The last dues increase was in 1987.

State dues of \$25 per member is a small amount to pay for the benefits received. Your county leaders are trained and kept informed of the latest health concerns, and the state and national alliances should be viewed as an excellent resource for all members. Your continuing support is needed and appreciated. □

Alliance convention to be held in Indianapolis Oct. 20-22

M.D. spouses, mark your calendars for Oct. 20, 21 and 22! The ISMA Alliance Convention will be held at the Westin Hotel in Indianapolis, and we want you to come. This is the first meeting held at the same time as the physicians' annual meeting, and it will be worth your time.

The schedule is as follows:

Thursday, Oct. 20

- Board meetings. Anyone is welcome.
- Evening: Casual networking time to get acquainted and network with others from around the state.

Friday, Oct. 21

- Attend ISMA House of Delegates. Hear what's happening from the physicians and the alliance.
- Lunch will honor the former state presidents.
- Opening business sessions.
- Dinner honors the current county presidents. Spouses are invited. The speaker will be rock musician Jimmy Ryser, who will talk about his spina bifida and also perform.
- Informal reception for new alliance president. Line dancing featured.

Saturday, Oct. 22

- Health care reform program.
- IMPAC luncheon.
- Final business session, featuring speaker on domestic violence.
- Dinner/dance in the evening.

A more detailed, confirmed agenda will be mailed to alliance members in September. Child care will be available. □

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Early thermometers gain acceptance slowly

Oren S. Cooley
Indianapolis

Unstandardized scales, inadequate control of fluid and the lack of sophistication delayed the widespread acceptance of the thermometer as a valuable diagnostic instrument.

In the 1600s, physicians became interested in those physiological conditions under which body temperature should change. As a result, physicians began to explore the possibilities of recording temperature by transferring a patient's body heat to a glass tube.

The three types of thermometers introduced during the 1600s differed in their fluid content, which consisted of either air, spirit or alcohol, or mercury. Many thermometers were coiled or curved in nature until physicians realized that air responds as quickly to pressure as to heat.

Besides the problems with their shapes, the tubes for spirit- or mercury-based thermometers also proved inadequate to control the even expansion those fluids undergo when heated. As a result, the mercury-based instruments were abandoned until a smaller more uniform bore could be made in the thermometer's tube.

During the late 1600s and early 1700s, thermometers still lacked universal scales, and therefore, physicians continued their practice of comparing the patient's temperature to the temperature of the person taking the measurements. However, the development of standardized temperature scales by Daniel Gabriel Fahrenheit and Anders Celsius in the 1700s enabled physicians to determine the average body temperature with either scale.

The uniform expansion of mercury prompted its reintroduction commercially as the preferred liquid for thermometers in 1822, when a method was developed to produce the uniform bore for the thermometer's tube. John Phillips, a professor of geology at Oxford University, England, designed the self-registering thermometer in 1832.

This type of thermometer, sometimes as long as 10 inches, contained a half-inch portion of mercury, called an index, that remained separated from the column of mercury by an air space. Although the mercury column receded after the thermometer was removed from the patient, the index remained at the registered temperature until the physician shook the thermometer.

Despite these advances, the thermometer continued to lack appeal during the middle 1800s because the instrument did not directly contribute to the prevailing diagnostic patterns. Physicians during this time began to consider alterations of body structure and function as the ultimate foci of disease and desired elaborate

instruments and laboratory tests to uncover these alterations.

These specialized tools contrasted greatly with the thermometer, which measures the general phenomenon of body temperature. Coupled with problems of calibration and breakage, this factor relegated the thermometer to its use in hospitals.

However, research-based physicians embraced the thermometer as another instrument capable of providing objective measurements. In 1868, German physician Carl Wunderlich published a monograph that examined the relationship between changes in body temperature and the courses many diseases followed.

As a result of such efforts, most physicians by the 1880s recognized the value of measuring body temperature. □

The author is director of the Indiana Medical History Museum in Indianapolis.

Source — Davis AB: Medicine and Its Technology: An Introduction to the History of Medical Instruments, 1981.



Self-registering thermometers, such as these 1865 instruments, used mercury because of its ability to expand evenly when heated.

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The Indiana Hand Center

The Indiana Hand Center in collaboration with St. Vincent Hospital will present "Treating Common Conditions of the Upper Extremity: A Proactive Approach for Primary Physicians" Sept. 21 at The Indiana Hand Center in Indianapolis.

For registration information, call Kevin Essington at (317) 471-4394.

Community Hospitals

Community Hospitals Indianapolis will present the "Fifth Annual Cardiovascular Symposium: Management Strategies for Primary Care Practitioners" Sept. 24 at the Embassy Suites in downtown Indianapolis.

For registration information, call Donna Grahm, (317) 355-5714.

American College of Cardiology

The American College of Cardiology will present "Advanced Echocardiography: Update 1994" Sept. 19 through 21 at the University Place Conference Center and Hotel in Indianapolis.

For more information, call the American College of Cardiology at 1-800-257-4739.

The Ear Institute

The Ear Institute of Indiana Inc. and Community Hospitals Indianapolis will present "Otology Update 1994" Sept. 21 at the Omni North Hotel in Indianapolis.

For more registration information, call (317) 842-4757 or 1-800-522-0734.

University of Wisconsin

The University of Wisconsin School of Medicine will present "Practical Approaches to Low Back Pain" Sept. 23 and 24 at the Holiday Inn-East Towne in Madison, Wis.

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University of Michigan

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Aug. 7-10 - Internal Medicine Update, Grand Hotel, Mackinac Island, Mich.

Aug. 15-20 - Pediatric Board Review, The Towsley Center, Ann Arbor, Mich.

Aug. 19-21 - Cardiology Update, Grand Hotel, Mackinac Island, Mich.

Sept. 20-21 - Advances in Body CT and MRI, The

Towsley Center, Ann Arbor, Mich.

Sept. 22-23 - Annual Seminar in Diagnostic Ultrasound 16th Anniversary Course, The Towsley Center, Ann Arbor, Mich.

Sept. 26-27 - Update on Pulmonary and Critical Care Medicine, The Towsley Center, Ann Arbor, Mich.

Sept. 28-29 - Office Procedures for Primary Care Physicians, Sixth Annual Workshop Course, The Towsley Center, Ann Arbor, Mich.

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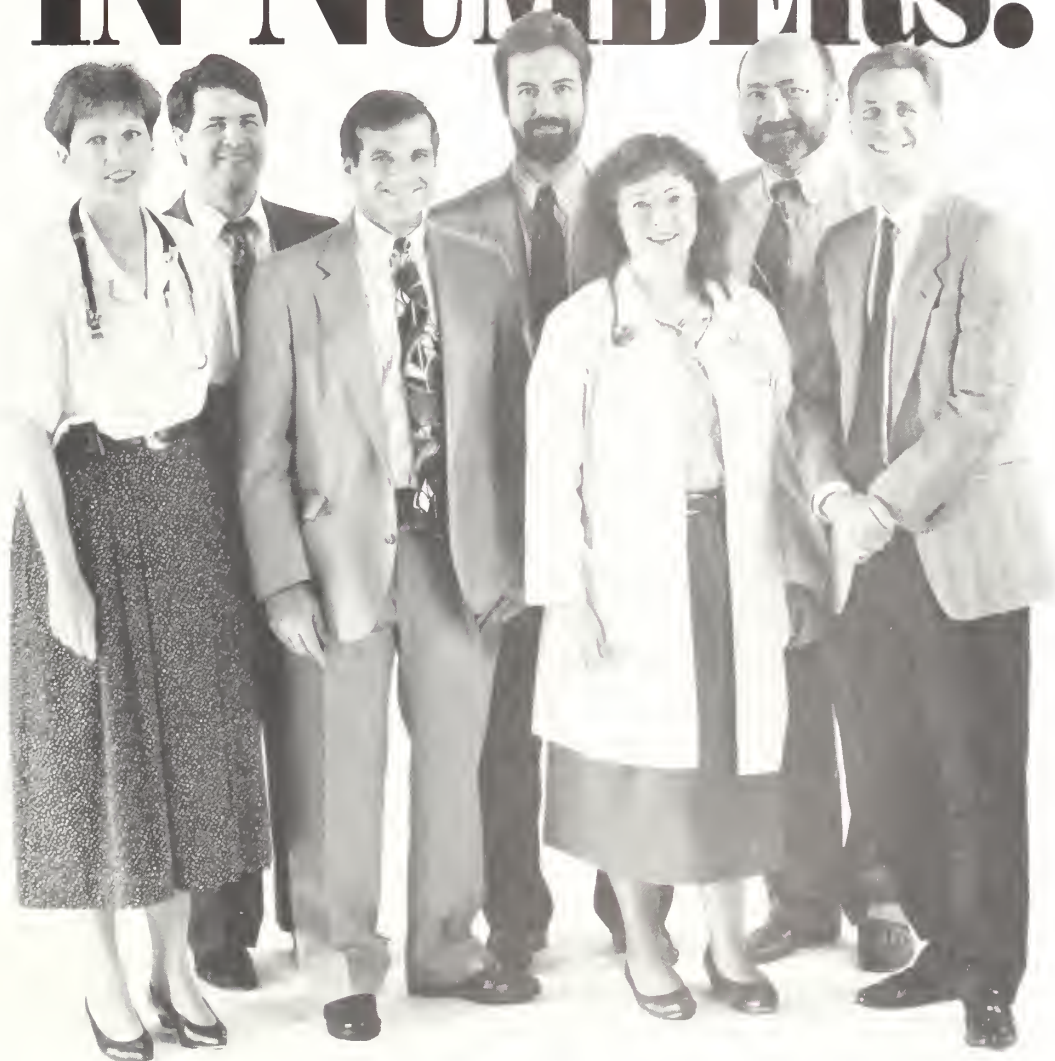
July 28-30 - Clinical Allergy for the Practicing Physician, The Ritz-Carlton Hotel, St. Louis.

Sept. 17 - Parkinson's Disease, Washington University Medical Center, St. Louis.

Sept. 24 - Anxiety and Depression, Washington University Medical Center, St. Louis.

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TRUSTEES (Terms end in October)

District

- 1 – Barney R. Maynard, Evansville (1995)
 - *2 – Jerome E. Melchior, Vincennes (1996)
 - 3 – Gordon L. Gutmann, Jeffersonville (1994)
 - 4 – Arthur C. Jay, Lawrenceburg (1995)
 - 5 – Fred E. Haggerty, Greencastle (1996)
 - 6 – Ray A. Haas, Greenfield (1994)
 - 7 – Ron Stegemoller, Danville (1995)
 - 7 – John M. Records, Franklin (1996)
 - 7 – Bernard J. Emkes, Indianapolis (1994)
 - 8 – John V. Osborne, Muncie (1996)
 - 9 – Stephen D. Tharp, Frankfort (1994)
 - 10 – Thomas A. Brubaker, Munster (1995)
 - 11 – Laurence K. Musselman, Marion (1996)
 - 12 – Joseph R. Manthey, Bluffton (1994)
 - 13 – Alfred C. Cox, South Bend (1995)
- RMS – Ruchir Sehra, Indianapolis (1994)
MSS – Scott Hollingsworth, Indianapolis (1994)

*Chairman

ALTERNATE TRUSTEES

(Terms end in October)

District

- 1 – Bruce W. Romick, Evansville (1994)
- 2 – James P. Beck, Washington (1995)
- 3 – John H. Seward, Bedford (1995)

- 4 – Lawrence R. Bailey Jr., Aurora (1994)
- 5 – Roland M. Kohr, Terre Haute (1994)
- 6 – Howard C. Deitsch, Richmond (1995)
- 7 – Frank Johnson, Indianapolis (1994)
- 7 – Paula A. Hall, Mooresville (1995)
- 7 – Girdhar Ahuja, Indianapolis (1996)
- 8 – Susan K. Pyle, Union City (1994)
- 9 – Daniel Berner, Lafayette (1995)
- 10 – John L. Swarner, Valparaiso (1994)
- 11 – Regino B. Urgena, Marion (1995)
- 12 – Brenda S. Stiles, Fort Wayne (1995)
- 13 – Richard J. Houck, Michigan City (1994)

RMS – Glenn A. Loomis, Indianapolis (1994)

MSS – Michael Hardacre, Miller Beach (1994)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1995)
John D. MacDougall, Indianapolis (1995)
Michael O. Mellinger, LaGrange (1995)
John A. Knote, Lafayette (1994)
Shirley Khalouf, Marion (1994)
George T. Lukemeyer, Indianapolis (1994)

AMA ALTERNATE DELEGATES

(Terms end Dec. 31)

Barney Maynard, Evansville (1995)
George Rawls, Indianapolis (1995)
William Beeson, Indianapolis (1995)
Max N. Hoffman, Covington (1994)
C. Dyke Egnatz, Schererville (1994)
Alfred Cox, South Bend (1994)

DISTRICT OFFICERS & MEETINGS

- 1 - Pres: Mariellen Dentino, Evansville
Secy: Dean Beckman, Jasper
Annual Meeting: May 18, 1995
- 2 - Pres: Gene Bourgasser, Sullivan
Secy: E. Steve Du Pre, Sullivan
Annual Meeting: May 11, 1995
- 3 - Pres: Daniel Cannon, New Albany
Secy: C. Montgomery Hocker, New Albany
Annual Meeting: May 17, 1995
- 4 - Pres: Alan Kohlhaas, Lawrenceburg
Secy: Gerald Bowen, Lawrenceburg
Annual Meeting: May 3, 1995
- 5 - Pres: Warren Macy, Greencastle
Secy: Rahim Farid, Brazil
Annual Meeting: May 25, 1995
- 6 - Pres: Helen Steussy, New Castle
Secy: to be announced
Annual Meeting: May 10, 1995
- 7 - Pres: Paula Hall, Mooresville
Secy: John Schneider, Indianapolis

- Annual Meeting: June 29, 1994
- 8 - Pres: Kathleen A. Galbraith, Portland
Secy: Mark A. Haggenjos, Portland
Annual Meeting: June 7, 1995
- 9 - Pres: Herschell Servies, Lebanon
Secy: Stephen D. Tharp, Frankfort
Annual Meeting: June 14, 1995
- 10 - Pres: Frank Hieber, Munster
Secy: Floyd Manley, Hammond
Annual Meeting: to be announced
- 11 - Pres: William D. Dannacher, Wabash
Secy: Jack Higgins, Kokomo
Annual Meeting: Sept. 14, 1994
- 12 - Pres: Joseph Manthey, Bluffton
Secy: Brenda Stiles, Fort Wayne
Annual Meeting: Sept. 15, 1994
- 13 - Pres: Donald Smith, South Bend
Secy: John W. Schurz, South Bend
Annual Meeting: to be announced

COMMISSION CHAIRMEN

Constitution and Bylaws

Fred W. Dahling, New Haven

Legislation

Barney Maynard, Evansville

Physician Assistance

Robert Nelson, South Bend

Medical Education

Glenn J. Bingle, Indianapolis

Sports Medicine

George Underwood, Lafayette

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Grievance

Richard B. Schnute, Indianapolis

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Communications

Mike Abrams, Director of Marketing/

Legislation

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Susan Grant, Executive Assistant

Richard Ryan, Field Services (Northern)

Bob Sullivan, Field Services (Central)

Janna Kosinski, Field Services (Southern)

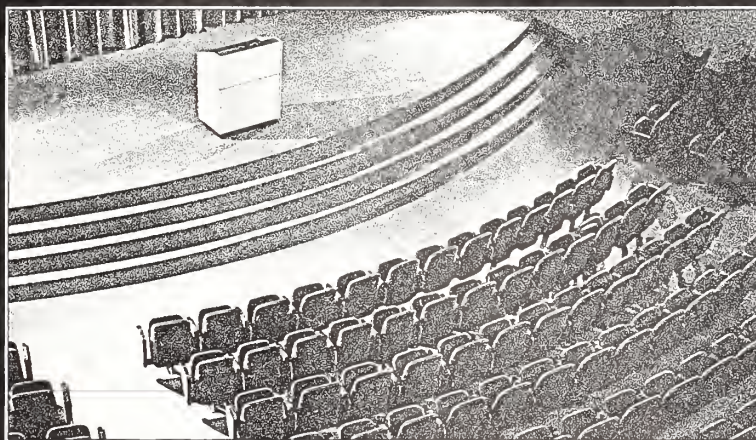
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Consultant

Meg Patton, Practice Management

Consultant

Tom Martens, Members Health Insurance

Tina Sims, INDIANA MEDICINE



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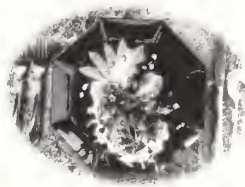
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■ obituaries

Robert F. Barton, M.D.

Dr. Barton, 75, a retired Angola family physician, died March 9, 1994, at his home.

He was a 1942 graduate of the Indiana University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Barton retired in 1990. He was a member of several organizations, including the Angola Masonic Lodge, the Fort Wayne Scottish Rite and the Angola Moose Lodge.

Joe H. Carr, M.D.

Dr. Carr, 69, a Henryville family physician, died April 2, 1994, at Jewish Hospital in Louisville.

He was a 1955 graduate of the University of Louisville School of Medicine and an Army veteran of World War II.

Dr. Carr was a staff member of Clark Memorial and Scott Memorial hospitals and The Medical Center of Southern Indiana and a co-founder of the Henryville Clinic. He also operated the Clark Memorial Hospital Clinic.

James S. Fitzpatrick, M.D.

Dr. Fitzpatrick, 73, a retired Portland surgeon, died May 9, 1994.

He was a 1944 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Fitzpatrick, formerly of Indianapolis, practiced in Portland for 37 years, retiring in 1987. He also was Jay County coroner and deputy coroner for 20 years.

Clementine E. Frankowski, M.D.

Dr. Frankowski, 87, a retired Whiting physician, died April 13, 1994, at St. Catherine Hospital in East Chicago.

She was a 1933 graduate of the Loyola University Stritch School of Medicine.

Dr. Frankowski continued her practice at the Whiting Clinic until she retired in December 1992. She was the Hammond health official in the 1960s, making her Indiana's first woman municipal health official. She had been on the staff at St. Catherine Hospital and had served as president of the Northwest Indiana Heart Foundation. She was a member of the American Medical Women's Association, the Association of American Physicians and Surgeons and the American Academy of Family Physicians.

Meredith B. Gossard, M.D.

Dr. Gossard, 77, a Tipton family physician, died April 13, 1994, at his home.

He was a 1939 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Gossard practiced in Tipton from 1949 until his retirement in 1986. He served as county health officer for several years and held various offices at Tipton County Memorial Hospital. He was the 1991 grand marshal of the Tipton County Pork Festival.

Forrest R. La Follette, M.D.

Dr. La Follette, 76, a retired Munster family physician, died April 28, 1994, at the Americana Healthcare Center in South Holland.

He was a 1942 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. La Follette practiced at the Whiting Clinic for 36 years before retiring in 1983. He was a member of the medical staffs of St.

Catherine Hospital in East Chicago, the Community Hospital in Munster and St. Margaret Hospital in Hammond. He was a fellow of the American Academy of Family Physicians.

Ottis N. Olvey, M.D.

Dr. Olvey, 77, a retired Indianapolis internist, died March 16, 1994.

He was a 1941 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Olvey practiced internal medicine about 40 years. He was on the staffs of Winona Memorial and Methodist hospitals before retiring in 1985. He had served as chief of staff at Winona and as a Marion County deputy coroner. He was treasurer of the Indiana State Medical Association from 1964 to 1967.

Ben B. Raney, M.D.

Dr. Raney, 92, a retired Linton anesthesiologist, died Feb. 14, 1994, at Glenburn Nursing Home.

He was a 1930 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Raney was a Linton physician for more than 50 years. He was known for his support of causes such as the Indiana University School of Medicine, the local library and the Glenburn Home.

Alvin D. Schaaf, M.D.

Dr. Schaaf, 92, a retired Jamestown family physician, died April 12, 1994, in Culver Union Hospital in Crawfordsville.

He was a 1931 graduate of the Indiana University School of Medicine.

Dr. Schaaf had a practice in Jamestown from 1931 to 1978, when he retired. He had been on

the staffs at Culver Union Hospital, Methodist Hospital in Indianapolis and Witham Memorial Hospital in Lebanon. He was a member of the American Academy of Family Physicians.

Elsworth K. Stucky, M.D.

Dr. Stucky, 84, a retired Indianapolis family physician, died May 9, 1994, at St. Francis Hospital in Beech Grove.

He was a 1940 graduate of the Indiana University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Stucky was in practice for

32 years before retiring in 1986. He was president of the St. Francis Hospital medical staff in 1971 and had received the hospital's 40-year service award.

Bryce P. Weldy, M.D.

Dr. Weldy, 85, a retired Hartford City otolaryngologist, died Feb. 19, 1994.

He was a 1933 graduate of the Indiana University School of Medicine.

Abram S. Woodard Jr., M.D.

Dr. Woodard, 85, a retired Indianapolis family physician, died

April 21, 1994, at St. Vincent Hospital.

He was a 1934 graduate of the Indiana University School of Medicine.

Dr. Woodard retired in 1986, after more than 50 years in private practice. He also was plant physician for Schwitzer-Cummins Co. and had been tournament physician for the U.S. Open Clay Court Championships in Indianapolis. He was a volunteer physician at the Indianapolis Motor Speedway during May. □



Dr. Dolan

Dr. Patrick A. Dolan has been named clinical associate professor emeritus of radiology at the Indiana University

School of Medicine.

Dr. Alan J. Habansky of Muncie is the new president of the Indiana Orthopaedic Society. Other officers are **Dr. Edward L. Brundick**, Evansville, president-elect; **Dr. William B. LaSalle**, Fort Wayne, board member-at-large; and **Dr. Clyde B. Kernek**, Indianapolis, secretary-treasurer.

Dr. Steven R. Smith, director of occupational health and medicine for Community Hospitals of Indianapolis, presented a lecture on "How to Manage New Industrial Illnesses" at the Worker's Compensation Update sponsored by the Council on Education in Management.

Dr. Christopher D. Prevel and **Dr. Rajiv Sood**, both of the Section of Plastic Surgery at the Indiana University Medical Center, were co-chairmen of the scientific program of the annual meeting of the Ohio Valley Society for Plastic and Reconstructive Surgeons held in Indianapolis. Dr. Prevel was named a consultant on a NIH grant on "A Biomaterial to Promote Skin and Wound Healing."

Dr. Rashid A. Khairi of Indianapolis was inducted as a fellow of the American College of Endocrinology.

Activities and accomplishments of physicians at The Indiana Hand Center in Indianapolis include the following: **Dr. James W. Strickland** was the honored

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

March

Akin, Daniel P., New Albany
Allman, Rex A., Winamac
Bhojraj, Deepak G., Hobart
Clark, Jack P., Syracuse
Clements, Robert E., Greenfield
Cornett, G. Mitch, Franklin
Dick, William H., Indianapolis
Feldner, Mark A., Munster
Fretz, Richard C., Kokomo
Guttman, Joanne K., Brookville
Hatvani, Catherine L., West Lafayette
Higgins, Jack W., Kokomo
Joshi, Prakash N., Marion
Kinsey, Helen S., Columbus
Lillo, Robert A., Indianapolis
Martin, Thomas J., Gosport
McClure, Richard O., Indianapolis
Miller, L. Hoyt, Indianapolis
Moayad, Cyrus, Valparaiso
O'Brien, Francis E., Rensselaer
Orr, Richard R., Evansville
Sando, William C., Indianapolis
Wenzler, Paul J., Bloomington

April

Bain, David R., Carmel
Bicalho, Jose F., Merrillville
Colalillo, Alessandro, Logansport
Dominik, Joseph D., Frankfort

DuBois, Don R., Greenwood
Fortner, William R., New Albany
Gibson, Alois E., Richmond
Gordon, Mark, Munster
Harper, Michael E., Tipton
Hatler, Douglas J., Evansville
Hchemann, William V., Munster
Hibbeln, Frederic P., Indianapolis
Hughes, William B., Waterloo
Johnson, Brian A., Winamac
Johnson, Harold V., Evansville
King, Mark A., Fort Wayne
Knight, Harry C., Indianapolis
Koontz, James A., Vincennes
Kubley, Jon B., Plymouth
Leon, Mario, Jasper
Lustig, William F., Columbus
Martin, Freeman, Indianapolis
Muhler, Joseph C., Fort Wayne
Murray, Richard P., Evansville
Nale, Stephen W., New Albany
O'Connor, Thomas M., Greenfield
Patel, Kant, Connersville
Rhynearson, William R., Indianapolis
Richter, Lawrence J., Terre Haute
Riedford, Richard A., Muncie
Sabens, James A., Indianapolis
Sechrist, Keeter D., Indianapolis
Weiss, Elaine H., Munster

guest lecturer at the New Jersey, New York and Connecticut Orthopaedic Societies' annual spring meeting in St. Maarten; he spoke on "Current Trends in the Treatment of Flexor Tendons" and "Hypothenar Fat Pad Flap for Recalcitrant Carpal Tunnel Syndrome." Dr. Stickland served on a panel on "U.S. Health Care Re-

form - Is It Working and For Whom? Representation in Government - Has It Helped? Can We Do More?" at the American Society for Surgery of the Hand meeting in Indian Wells, Calif. He gave presentations on "Tenolysis: A Clinical Experience" and "Acute Flexor Tendon Repair with Active Mobilization: Indianapolis

Technique" at a meeting sponsored by the Hand Rehabilitation Foundation and the Jefferson Medical College of Thomas Jefferson University in Philadelphia. **Dr. Hill Hastings II**, as an international trustee for AO-International, was a faculty member for the AO/ASIF Hand Course in Singapore. His duties included serving as a "visiting expert" to the Ministry of Health. He gave lectures and moderated panels on subjects including "Advances in Tendon Surgery," "Principles of Treatment - Metaphyseal-Intraarticular Fractures," "Wrist Arthrodesis," "Condylar Fractures" and "Correctional Osteotomy Distal Radius."

Dr. Kevin L. Waltz, an Indianapolis ophthalmologist, recently published his first book on eyelid surgery. Written with Dr. Frank A. Nesi, *Smith's Practical Techniques in Ophthalmic Plastic Surgery* is a comprehensive atlas of basic surgery for eyelids, tear ducts and orbital fractures. His article on "Basal Cell Carcinoma of the Eyelid and Periocular Skin" was published in *Ophthalmology*.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke at a meeting on the fundamentals of rhinoplasty sponsored by the American Academy of Facial Plastic Surgery in Memphis, Tenn.; his topics were "Altering Nasal Length and Width," "Tip Augmentation" and "The Asymmetrical Tip."

Dr. Caitilin Kelly, a Bloomington internist, has been board-certified in critical care medicine.

Dr. William Beeson, an Indianapolis facial plastic and reconstructive surgeon, was invited to lecture on "Surgical Closures for Facial Defects" and "Chemical

Peels" at the Current Concepts in Dermatology course in Orlando, Fla. He spoke on "Implants and Grafts in Revision Nasal Surgery" and "The Difficult Rhinoplasty" at the World Congress on Rhinoplasty in Philadelphia.

Dr. Barbara K. Siwy, an Indianapolis plastic surgeon, gave two lectures at the American College of Surgeons annual meeting in Puerto Rico; her topics were "Magnetic Resonance Imaging in the Diagnosis of Silicone Gel Breast Implant Rupture" and "Sensibility in the Reduced Breast: How Insensate is a Free Nipple Graft?"

Dr. Bruce Waller of Nasser, Smith & Pinkerton Cardiology in Indianapolis spoke on "Pathology of Various Interventional Procedures" at a program sponsored by the Harvard Medical School at Deaconess Hospital in Boston.

Dr. Matthew D. Bruns has joined Northeast Otolaryngology P.C. in Noblesville.

Dr. Ted L. Grisell, a retired Indianapolis surgeon, was honored as the outstanding physician of the year by the American Society of Abdominal Surgery. He served as president for two terms and was the chairman of the society's certification board for several years. He recently compiled his humor columns, many of which were published in *Indiana Medicine*, into a book titled *Medicine's Lighter Moments*. The 172-page book is available for \$20 by calling the office of his son, Dr. Ted W. Grisell, (317) 359-8261, or writing to him at 5317 E. 16th St., Indianapolis, IN 46218.

Dr. Herschell Servies Jr., a Lebanon family practitioner, was elected chief of staff at Witham Memorial Hospital in Lebanon.

Dr. Joseph C. Copeland, an

obstetrician/gynecologist, was elected president of the medical staff at Community Hospital in Anderson. Other officers are **Dr. David A. Shapiro**, family practitioner, chief of staff, and **Dr. J. Douglas Smith**, family practitioner, vice president.

Dr. John Roberts of Washington, Ind., was appointed aeromedical examiner for Daviess County by the Federal Aviation Administration.

Dr. Jack P. Clark, a Syracuse family practitioner, was named the Citizen of the Year by the Syracuse-Wawasee Chamber of Commerce.

Dr. Maurice E. John, a Jeffersonville ophthalmologist, spoke at the Greek Intraocular Lens Implant Society meeting in Athens; his topics were cataract surgery and refractive surgery with the excimer laser. Dr. John has been certified in the subspecialty of refractive surgery by the American Board of Eye Surgery.

The new alumni center at Vincennes University has been named in honor of **Dr. Louie O. Dayson**, a Vincennes cardiologist, in recognition of his donation toward construction of the building.

Dr. Sandra L. Gadson, a Gary nephrologist, was elected president of the medical staff at the Methodist Hospitals. Other officers are **Dr. Adel H. Ayoub**, an anesthesiologist, secretary, and **Dr. George Clardy**, a family practitioner, treasurer.

Dr. Nabil A. Gayed, a general surgeon, was elected chief of staff at Huntington Memorial Hospital. Other officers are **Dr. Roy Weston**, an anesthesiologist, vice chief, and **Dr. David Carnes**, family practitioner, secretary.

Landscape photographs taken

■ people

by **Dr. Clarence Boone**, a Gary obstetrician/gynecologist, were displayed at the Gary Mental Health Center Atrium Gallery.

Dr. Wendell Riggs, a Lafayette pediatrician, received a George Award from the Lafayette Journal and Courier for his work in establishing the Tippecanoe County Community Health Clinic. The award recognizes people who have performed a public service without thought of reward or financial compensation.

Dr. Stanley M. Chernish of Indianapolis was named the 1994 Central Indiana Volunteer of the Year by the United Way of Central Indiana Volunteer Action Center. Methodist Hospital nominated him for his voluntary work in the research of new diagnostic technologies in gastrointestinal diseases.

Dr. Brandt L. Ludlow, an obstetrician/gynecologist, was elected chief of staff at Bloomington Hospital.

Dr. Robert L. Allen of Columbus was certified by the American Board of Urology.

Dr. Martha J. Dwenger of Columbus was certified in diagnostic radiology by the American Board of Radiology.

Dr. Mark E. Hatfield and **Dr. Melinda W. Hunnicutt**, both of Columbus, were certified in cardiovascular disease by the American Board of Internal Medicine.

Dr. John H. Mahon of South Bend and **Dr. Annabella Juhasz** of Michigan City were inducted as fellows of the American Academy of Orthopaedic Surgeons.

Dr. Richard T. Swanson, a rheumatologist and physical medicine specialist at Welborn Clinic in Evansville, received the W. Frank Wood Jr. Lifetime Achievement Award from the

Arthritis Foundation of Southern Indiana. He received the award, the foundation's top honor, for his work as a medical expert and fund-raiser.

Dr. Thomas L. Sevier, a primary care sports medicine specialist at Central Indiana Sports Medicine in Muncie, wrote a chapter on "Infectious Disease in Athletes" that was published in the March issue of *Medical Clinics of North America*.

Dr. Gordon Fessler of Aurora received a plaque from the Switzerland County Council for his 53 years of service as a physician in Rising Sun.

Dr. Thomas P. Krueger, a neurosurgeon, and **Dr. James A. Robertson**, an anatomic and clinical pathologist, were honored for their 25 years of service by St. Mary's Medical Center in Evansville.

Dr. Dolph M. Denny of Jeffersonville has been board certified in cardiovascular disease.

Dr. Barbara Backer, a LaPorte cardiologist, received the Michiana Executive Journal's Journi Award for Professional of the Year. The award is given to leaders dedicated to making their communities a better place. She helped plan and implement the LaPorte Hospital critical care unit, the stress center and the medical education department.

New ISMA members

Christian L. Ballast, M.D., Shelbyville, pediatrics.

Greg Ballengee, M.D., Muncie, obstetrics and gynecology.

Stewart E. Bick, M.D., Carmel, emergency medicine.

G. David Bojrab, M.D., Indianapolis, anesthesiology.

Keith E. Brandt, M.D., New

Castle, family practice.

Thomas P. Broderick, M.D., Marion, anesthesiology.

John M. Brumfield, M.D., Anderson, anesthesiology.

Margaret A. Brummer, M.D., Elkhart, emergency medicine.

Mary R. Brunner, M.D., Zionsville, pediatrics.

Matthew D. Bruns, M.D., Noblesville, otolaryngology.

Beth L. Buchanan, M.D., Fortville, family practice.

Barbara Burke, M.D., Batesville, emergency medicine.

Anise T. Burki, M.D., Indianapolis, anatomic pathology.

Elizabeth A. Burrows, M.D., Greenfield, anesthesiology.

Louis B. Cady, M.D., Evansville, psychiatry.

Barbara E. Carr, M.D., Munster, diagnostic radiology.

Robert D. Chaney, M.D., Columbia City, anesthesiology.

Gregory L. Chupp, M.D., Fremont, family practice.

Thomas J. Connor, M.D., Carmel, emergency medicine.

Judy L. Davis, M.D., Lafayette, family practice.

Daniel J. Drew, M.D., Indianapolis, family practice.

Christina C. Drummond, M.D., Muncie, emergency medicine.

Rebecca S. Eglen, M.D., Avon, pediatrics.

Rhonda Elam, M.D., New Albany, pediatrics.

David M. Evans, M.D., Evansville, anatomic/clinical pathology.

Kent Farnsworth, M.D., Zionsville, internal medicine.

Sheema Farooqui, M.D., Fort Wayne, pediatrics.

William R. Farrell, M.D., South Bend, emergency medicine.

D. Michelle Fenoughty, M.D., Muncie, obstetrics and gynecology.

Shawn W. Fenoughty, M.D., Muncie, pediatrics.

Robin A. Fox, M.D., Muncie, emergency medicine.

Luis L. Galang, M.D., Indianapolis, family practice.

Christine R. Gest, M.D., Evansville, cardiovascular surgery.

William L. Graham, D.O., Connersville, general practice.

Walter H. Halloran, M.D., South Bend, thoracic surgery.

Sherry L. Hamilton, M.D., Carmel, emergency medicine.

James W. Hardacker, M.D., Carmel, orthopaedic surgery.

Kenneth H. Harvey, M.D., Carmel, emergency medicine.

William M. Hughes, M.D., Carmel, emergency medicine.

Mary Hyder, M.D., Indianapolis, family practice.

Charles E. Hyre, M.D., Indianapolis, general surgery.

Steven P. Jardina, M.D., Carmel, emergency medicine.

Preetham Jetty, M.D., Indianapolis, cardiovascular diseases.

David R. Johnson, M.D., Carmel, emergency medicine.

James H. Jones, M.D., Indianapolis, emergency medicine.

Steven C. Kaiser, M.D., Muncie, gastroenterology.

Lisa G. Kinderman, M.D., Danville, internal medicine.

Paul M. Kramer, M.D., Evansville, occupational medicine.

Robert A. Lew Jr., M.D., Carmel, emergency medicine.

John A. Lucich, M.D., Carmel, emergency medicine.

Michael J. Malnofski, M.D., Muncie, diagnostic radiology.

Mary L. Mayer, M.D., Indianapolis, oncology.

Kevin G. McAree, M.D., Indianapolis, general surgery.

Brent W. Mohr, M.D., South Bend, rheumatology.

Julio A. Morera, M.D., Evansville, pediatrics.

Murugavel Muthusamy, M.D., Michigan City, hematology.

James R. Nossett, M.D., Danville, emergency medicine.

Mark A. O'Shaughnessy, M.D., Fort Wayne, internal medicine.

Thomas J. Petrin, M.D., Indianapolis, internal medicine.

Stephen H. Pollom, M.D., Indianapolis, internal medicine.

Robert J. Porte, M.D., Portage, family practice.

Matura S. Rao, M.D., Valparaiso, cardiovascular diseases.

Tresa V. Ratterman, M.D., Clarksville, pediatrics.

Patrick D. Reibold, M.D., Indianapolis, neurology.

Laura L. Reske, M.D., Indianapolis, psychiatry.

Laura M. Reuter, M.D., Indianapolis, reproductive endocrinology.

Paul Rober, M.D., Logansport, urological surgery.

Roy W. Robertson, M.D., Fort Wayne, internal medicine.

Corbin P. Roudebush, M.D., Indianapolis, endocrinology.

Jerry L. Rushton II, M.D., Indianapolis, pediatrics.

Michael A. Salvato, M.D., Muncie, family practice.

David Q. Santos, M.D., Indianapolis, otolaryngology.

Patrick C. Santos, M.D., Muncie, family practice.

Howard L. Schafer, M.D., Lafayette, obstetrics and gynecology.

Taiseer J. Shatara, M.D., Indianapolis, internal medicine.

Stephen Shoemaker, D.O., Boonville, general practice.

Paul A. Skierczynski, M.D., Indianapolis, internal medicine.

Richard W. Skupski, M.D., South Bend, anesthesiology.

Ernest J. Stanley, M.D., Evansville, gastroenterology.

Susan A. Stephens, M.D., Carmel, emergency medicine.

Thomas C. Stock, D.O., Evansville, family practice.

Deborah D. Stoner, M.D., Evansville, family practice.

Mangalore J. Subba Rao, M.D., Knox, general surgery.

Mureena A. Turnquest, M.D., Indianapolis, obstetrics and gynecology.

Donald J. Vennekotter, M.D., Evansville, general surgery.

Prayuk A. Waran, M.D., Merrillville, obstetrics and gynecology.

Thomas L. Whittaker, M.D., Indianapolis, oncology.

Steven L. Wise, M.D., Indianapolis, allergy and immunology.

Jonathan P. Yim, M.D., Muncie, anesthesiology.

Marc E. Young, M.D., Carmel, emergency medicine. □

■ classifieds

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Advertising index

AdminaStar	321
American College of Surgeons	267
American Medical Association Purchase Link	337
Arnett Clinic	319
Auto Purchasing Unlimited	338
Bethesda Group Practice	274
Central Pharmaceuticals	265
HBI Recruiter	299
ISMA Insurance Agency	275, Covers
Krieg DeVault Alexander & Capehart	297
Medical Protective	289
Palisades Pharmaceuticals	264
Physicians' Directory	304
Physicians Insurance Co. of Indiana	Cover
Price, T. Rowe	303
Reeves Hummer	283
Rehabilitation Hospital of Indiana	325
Roche Laboratories	269
The Money Store	323
U.S. Air Force	282
University Place	327

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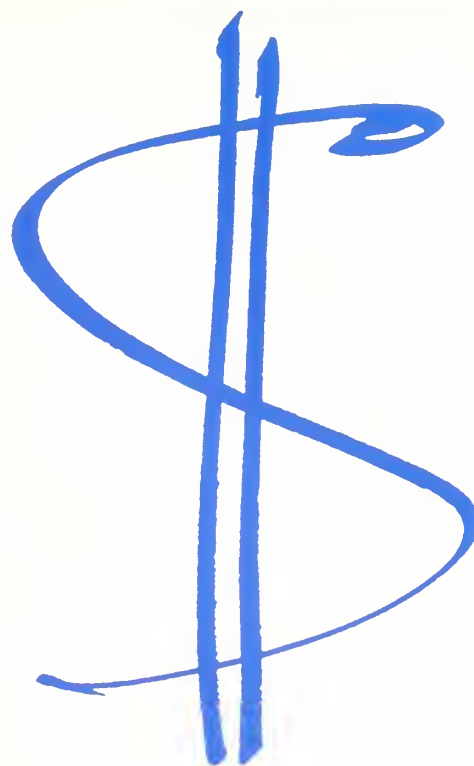
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1,000	<ul style="list-style-type: none"> \$1,000 calendar year deductible, \$2,000 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		
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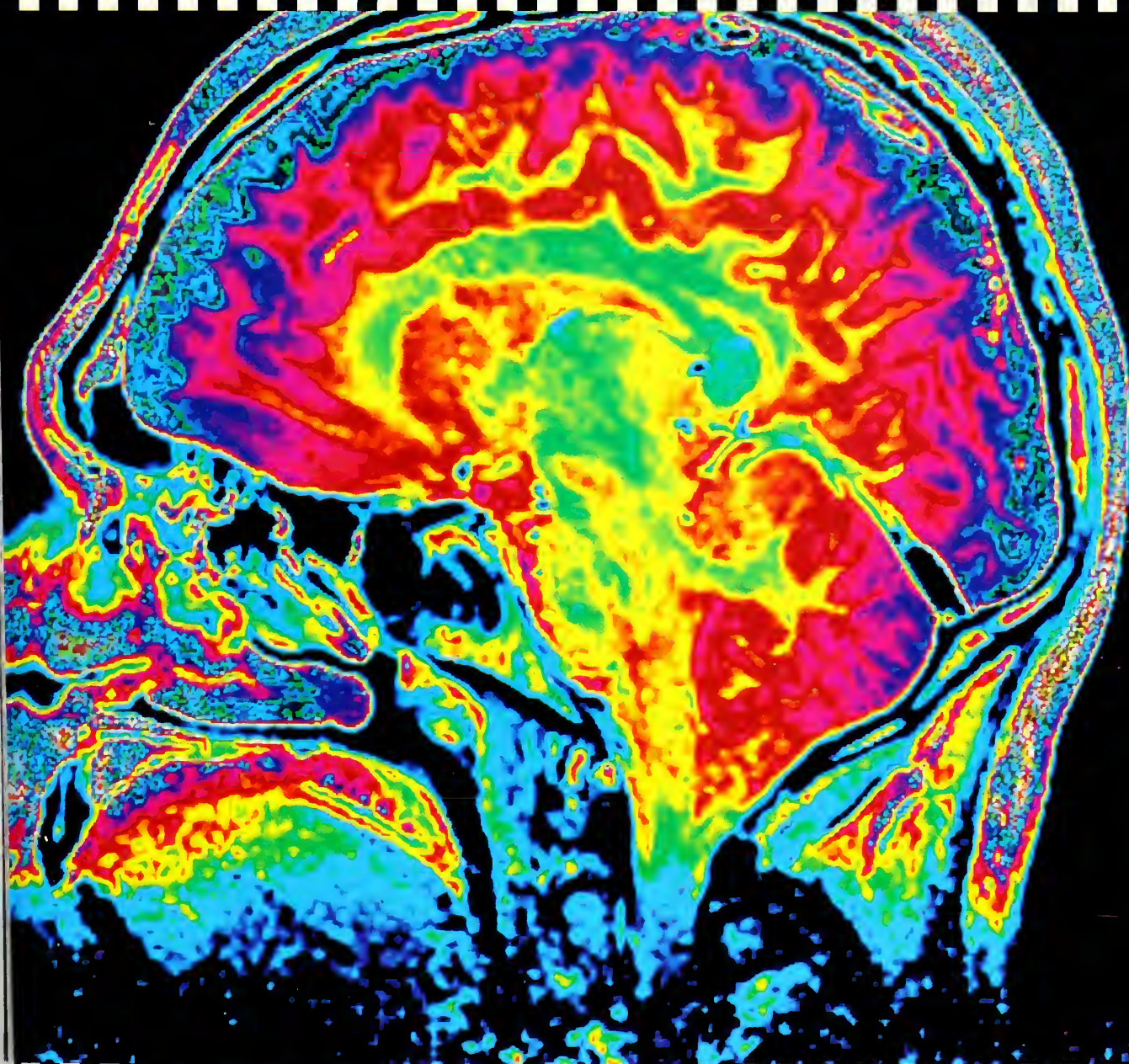
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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

September/October 1994

Vol. 87, No. 5



HEALTH CARE 2000 WHAT'S AHEAD IN REFORM & TECHNOLOGY

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INDIANA MEDICINE

The Journal of the Indiana State Medical Association

September/October 1994

Vol. 87, No. 5

features

Women urged to play role in organized medicine 346

INDIANA MEDICINE interviews Shirley Khalouf, M.D., a Marion physical medicine and rehabilitation specialist, about her role in organized medicine and the outlook for women physicians.

Telemedicine changing practice of medicine 352

Telemedicine can save time, money and possibly lives - which explains why patients, physicians and hospitals are learning to like this new technology.

Stark outlook for physician self-referrals 360

The anti-referral provisions of the Omnibus Budget Reconciliation Act of 1993 that go into effect Jan. 1, 1995, include some exceptions, many of which apply to group practices.

Case study analysis of physician hospital organizations 364

Successful physician hospital organizations share several common traits, according to a study undertaken by four medical associations, including the Indiana State Medical Association.

Institutional ethics committees in Indiana:

Organization, structure and function 370

Although the number of ethics committees is growing, a study concludes that some changes are needed if they are to be effective in improving patient care.

Choosing a practice management consultant 376

Quality practice management services can contribute significantly to the success of a medical practice.

Physician serves as advocate for abused 378

Domestic violence has been tolerated too long, says a Michigan physician who will speak at the ISMA convention.

1994 Annual Convention & Exposition 380

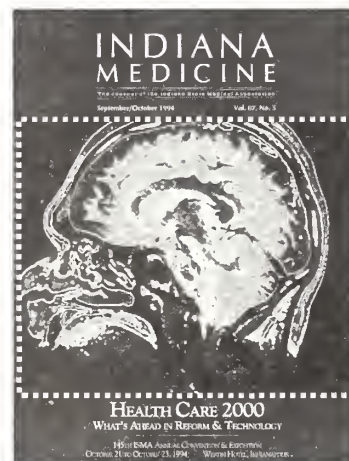
The 145th ISMA annual meeting will be Oct. 21 through 23 at the Westin Hotel in downtown Indianapolis.

- ISMA annual reports 388

- Status of 1993 resolutions 400

scientific contribution

A one-year review of the Eye Injury Registry of Indiana 406



Cover story begins on page 380. Cover design by Celeste Conover of Indianapolis. MRI view of brain cross-section provided by FPG International.

■ departments

stethoscope 342

letter to editor 344

drug names 377

alliance report 426

cme calendar 428

isma leadership 430

obituaries 432

news briefs 434

people 436

classifieds 440

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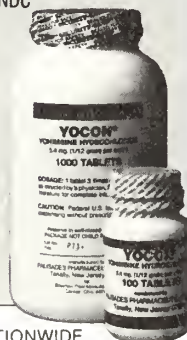
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Proposed amendment would pre-empt INCAP, any willing provider laws

ISMA members are encouraged to urge their U.S. senators and representatives to oppose an amendment to House Resolution 3600 that deals with medical liability. The proposed amendment would pre-empt any state law that is inconsistent with its provisions. If the amendment is adopted, the Indiana Compensation Act for Patients (INCAP) would be significantly affected.

The provisions limit attorney fees to 33 1/3% of the award. Currently INCAP limits attorney fees to 15% of the award from the Patients Compensation Fund. The amendment does not contain language limiting damage awards or statutes of limitation. INCAP contains both.

A separate provision would pre-empt state "any willing provider" laws. Indiana's any willing provider law guarantees patient freedom of provider choice in PPO contracts by requiring the PPO to allow any physician willing to accept the terms of the contract to be permitted to see patients in the PPO.

Physicians may express their opposition to these provisions by calling the U.S. Capitol switchboard, (202) 224-3121, and asking for their senator or representative by name and state or writing to their senator at U.S. Senate, Washington, DC 20510 or their representative at U.S. House of Representatives, Washington, DC 20515.

POs, quality assurance, capitation topics of Nov. 2 seminar

"Physicians Organizing for a New Market Place" is the focus of a daylong seminar to be presented Wednesday, Nov. 2, by the Indiana State Medical Association at the University Place Conference Center in Indianapolis. Speakers and topics confirmed at press time include James C. Dechene, J.D., Chicago, physician organizations; Alan Snell, M.D., South Bend, and Thomas Neal, J.D., Indianapolis, physician hospital organizations; Bill DeMarco, Rockford, Ill., capitation; and Tom Wolff, J.D., of the Michigan State Medical Society.

The cost is \$200 for members and \$300 for non-members. For details, call Meg Patton at the ISMA, 1-800-257-4762 or (317) 261-2060.

ISMA plans Medicine Day and Legislative Reception

ISMA members can meet their state legislators during the annual ISMA "Medicine Day" and the ISMA/IMPAC Legislative Reception Wednesday, Jan. 25, at the Hyatt Regency in Indianapolis.

Medicine Day activities will include a breakfast briefing on legislative issues by the ISMA staff, a visit to the Statehouse to meet with legislators and a lunch for physicians and legislators. Current Key Contact program participants and those interested in joining the program may attend Medicine Day.

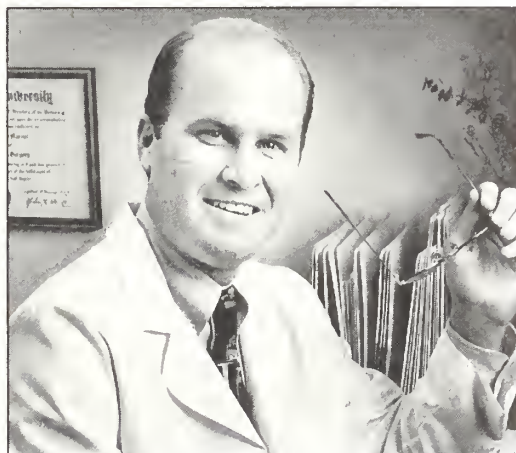
The legislative reception, featuring a "Beach Party" theme, will be from 6 p.m. to 8:30 p.m. Invitations will be mailed in December. □

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■ letter to editor

State official's comments called 'liberal pabulum'

I can't believe that the editorial board of *INDIANA MEDICINE* can't come up with some editorial response to the liberal pabulum offered to the physicians of the Indiana State Medical Association by Myra C. Selby in the July/August 1994 issue of *INDIANA MEDICINE* ("Doctors, state can be partners in reform").

You have got to be kidding me – a lawyer, and a liberal one at that, is the director of health care policy for the state of Indiana. You have got to be kidding me – health reform in the state of Indiana is going to be dictated by the findings of a Robert Wood Johnson Foundation Grant. The Robert Wood Johnson Foundation is the most liberal, left-leaning, socialized medicine embracing foundation, with the most money of any such organization in the country.

I will give you an example of how sincere Miss Selby and Gov.

Evan Bayh are of listening to physicians in Indiana. I wrote two letters to Gov. Bayh concerning the Medicaid Reenrollment Provider Agreement this year, the first dated April 6 and the second dated June 6. I received a response from a special assistant to the office of the governor dated July 11. This letter basically referred me to the Indiana Medicaid update dated June 28.

Until organized medicine comes to the realization that the federal government, the state government and all the bureaucrats in between give not one hoot about medical care and how it affects patients and physicians, we will continue to be dealt with as little children with nothing to say. Until organized medicine stands up to its responsibility to its members as well as to its patients and tells them how to run a medical system, our influence will continue to diminish, and our input will continue to be taken for what they

think it's worth, that being nothing. □

Michael Hansen, M.D.
Batesville

Editor's note: Before becoming the state's director of health care policy, Myra Selby specialized in health care law, representing physicians, at the Indianapolis law firm of Ice Miller Donadio & Ryan.

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., *INDIANA MEDICINE*, 322 Canal Walk, Indianapolis, IN 46202-3252. □

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Though most people survive for a significant period after the diagnosis of a critical illness, their families' financial security may not.

A plan is now available through the ISMA which pays a lump sum benefit upon the diagnosis of:

- Critical Illness
- Permanent Disability or
- Death

Indiana
State
Medical
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For more information on this plan please contact your ISMA Benefit Representative at **1-800-442-ISMA.**

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the quality of life
in the event of
critical illness.*

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Women urged to play role

Bob Carlson
Indianapolis

Women now make up 40% of the enrollment in medical schools. Twenty-five years ago, women were only 9% of the student body.

As more women become physicians and participate in organized medicine, the profession will need the leadership of women such as Shirley Thompson Khalouf, M.D. Dr. Khalouf is the immediate past chair of the AMA Women in Medicine Advisory Panel. She is also a delegate to the AMA House of Delegates and a member of the AMA Council on Constitution and Bylaws.

Dr. Khalouf practices physical medicine and rehabilitation at Marion (Ind.) General Hospital, where she just completed a term as chief of specialty services. A former chief of staff and chief of medical service at Marion General, Dr. Khalouf is also on the staff of Kokomo Rehabilitation Hospital. She is board certified in her specialty and is active in numerous professional organizations. She is a native of Pennsylvania and a graduate of the Medical College of Pennsylvania in Philadelphia.

She is the first and only woman to have served as president of the Indiana State Medical Association. She was one of the ISMA's key spokespersons in its successful campaign to protect the Indiana Compensation Act for Patients (INCAP).

In observance of the designation of September as Women in Medicine Month, INDIANA MEDICINE interviewed Dr. Khalouf. She talked about her involvement in organized medicine, the importance of mentoring, the challenges still facing women and what the

future might hold.

INDIANA MEDICINE: Why did you become involved in organized medicine?

Khalouf: Medicine was my profession and I was interested in being active in my medical organizations. I love the interplay with other physicians and being able to help physicians in the medical-political arena. This is what stimulated my interest and kept me going. You must remember that I started practicing when there were very few women physicians. I was the only woman in my internship at the Harrisburg Hospital. Once I started practicing, I was fortunate that there were some women physicians in this community. But my mentors, the ones who encouraged me to become active in organized medicine at the hospital and county level and then on up through the state, were men. I was very fortunate because not only did I have a loving husband, but I had a loving husband who was a physician and who said, "Shirley, go for it. Do what you want." We had good care for our children, which is also important.

INDIANA MEDICINE: Although more women are becoming involved in organized medicine, they are still not participating in the type of organizational activities, for example, that you're involved in, to the degree that men are. Why do you think that's so?

Khalouf: Probably because many women physicians are married and have families. It's my opinion that women still take the major role in child rearing and this



in organized medicine

sets them back a few years in becoming active in organized medicine. In the end, hopefully, we'll see just as many women active as men, percentage-wise. I have no statistics, but my gut feeling is that we're getting more and more interested and more and more active. Of course, we always have some women who don't fit the mold, someone like me who's been active all along, with a good husband's support.

INDIANA MEDICINE: What are some good ways for women to take those first steps in participating in organized medicine?

Khalouf: Young women become more involved in medical school now. I'm seeing that as I talk to medical students. They're getting active in the medical student organizations and then moving on to the residency level. Once in practice, I would hope that all physicians, including women, will get active at their local county and hospital level because that's where they can learn communication techniques and take responsibility. Not every physician, whether it be a man or woman, wants to take on a position of leadership. But we need both those who are at home working for the officers and we need the officers who are willing to take the responsibility and represent those at home.

INDIANA MEDICINE: Despite improvements, does gender bias still exist in the medical profession?

Khalouf: According to several of the articles I've read, yes, and according to some of the women

I've spoken to, yes. I think we'll see that disappear as the number of women gradually increases in the medical profession. As you know, by the year 2010, we are forecast to have at least 30% women practicing in the country. So we'll see some gender bias disappear that way, although we'd like to see it disappear faster, particularly since we, men and women, are aware that there

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The 'glass ceiling' is very real to women in the academic profession.

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is a problem of gender bias and gender discrimination. Because of that awareness, there are more and more policies to help prevent that and mechanisms to resolve things.

I understand that there are problems, particularly in the academic profession. The “glass ceiling” is very real to women in the academic profession. Now I'm not an academician, but one of the problems for women has to do with the tenure track and how there's no moving off that track in most institutions now. With the women having childbirth and child rearing responsibilities, they're often out of that system and aren't always getting to the same level and at the same rate as the men. They need a few more years to gain that position. Since everyone's becoming aware of it, hopefully that will be altered a little bit so that there's a way for

these women to also attain tenure. I understand there are many women associate professors, but not as many full professorships represented by women as one would expect from the number of women who go into academic medicine. The other thing is that academic grants aren't always given to women as much as men. Hopefully we'll see that change, too.

INDIANA MEDICINE: Can you give any examples of gender bias from your own experience or the experience of other women in medicine?

Khalouf: I've experienced very little. I've been very fortunate. Until a few years ago, I would probably have said I have not experienced it or that it's been minor, that I've shrugged my shoulders and kept on going. However, I was asked some questions in a group of women talking about past experiences, and I suddenly realized that I did have a



gender bias experience many years ago. I was trying to decide what specialty I would go into, and at that time I was thinking about either ophthalmology or physical medicine and rehab. I was torn between the two, but I thought I'd go into ophthalmology because I liked surgery and I thought I could limit my hours, since I wanted a family and I was already married. We were at the Cleveland Clinic. My husband had already started his residency, and I wanted to stay at the clinic also. But I found out that the chairman of the department of ophthalmology would not interview me because I was a woman. I could have gone outside that institution and gotten a residency, but since I was not quite sure which specialty I wanted to go into, that really is what made me become a physiatrist. I really had blocked out that experience, although at the time I was quite upset.

INDIANA MEDICINE: Can you think of any experiences of gender bias in the medical profession that women colleagues have shared with you?

Khalouf: Some of the women still say they have problems at the hospital staff level with positions and appointments. Unless you're really in that particular situation, it's hard to take sides. You have to be very objective and work toward equality for all without criticizing one side or the other. That's always been my philosophy: Keep an objective mind and keep working toward certain goals.

INDIANA MEDICINE: What is the

AMA Women in Medicine Advisory Panel, which you chaired this past year, doing to help women advance in their careers and in organized medicine?

Khalouf: This panel started in 1979 when there were very few women represented at the AMA level. It's very active now. Its goals are to give advice and counsel to the association, to the trustees and officers as well as to the staff on matters that pertain to policies or programs regarding women physicians and women medical students. There are 10

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This past year we have also been working with the Girl Scouts on a mentoring badge so that young Girl Scouts can work one on one with women physicians in their community.
”

members on the panel. Three of the seats are designated for a medical student, a resident and a young physician member. The others are practicing women physicians. As of June we did not have an academic woman physician on the panel, but we're hoping to have that also. We are a good resource for women all over the country. The panel has either authored or stimulated the creation of many reports by the AMA that have helped women.

The AMA formulated the policies on maternal leave, paternal leave, family responsibilities, gender discrimination, gender-neutral language and guidelines for the prevention of sexual harassment. Many other institutions have adopted our recommendations and have improved their own policies. The important thing is not only to recognize that there is a problem, but how to resolve the problem. You can have a policy paper, but if there's no way for the complaint to be heard and resolved, then it's not effective.

We also sponsor Women in Medicine Month. Hopefully all states, including Indiana, will soon have a Women in Medicine Committee so that we can foster membership and give support to women physicians. This past year we have also been working with the Girl Scouts on a mentoring badge so that young Girl Scouts can work one on one with women physicians in their community. The main goal is of course to interest young women in medicine. We also want to interest practicing women physicians in mentoring young women. We want to show them how this will help them and medicine in general. Hopefully, this will stimulate women membership in organized medicine and raise their awareness of what the AMA and the Women in Medicine Panel can do for them. That program is going to get off the ground this fall.

Mentoring is important, particularly for the medical student, the resident and then the young physician. Today, I think it's important for young people to know that their mentors can be either sex. In the educational programs

I think it's important that the mentor be outside the organized program itself so that there's no potential threat to the student or the young physician who might disclose a problem to a mentor who is an employed part of the educational program. That student or resident may not be as open to communicate problems, whereas if a man or woman mentor is outside the official educational program, perhaps more open dialogue will occur. For students or young physicians who don't have problems, mentoring shows how someone else handles a practice and deals with stress. The members of the AMA Advisory Panel for Women in Medicine feel that mentoring is a very important program that needs to be encouraged and enlarged.

I enjoy this kind of work. I hope that those of us on the Women in Medicine Panel are doing it to benefit other women physicians and medicine in general. I was very pleased to be appointed to the panel. I was very pleased to be elected chair. I think we've done good work, but there's still more to be done. Our goal is that the panel will no longer be needed in the future because needs will be met and we will be a homogeneous physician community of men and women and those special interest committees will no longer be needed. The goal is to see the panel's demise.

INDIANA MEDICINE: Nearly 40% of all medical students today are women. How will this change the physician practice profile and the delivery of medical care?

Khalouf: I don't think the number

of women physicians is going to change the practice profile and the delivery of care as much as the things that are going on in Congress right now. Women aren't going to change the quality or the quantity or the degree of skill in medicine. If anything, more women in medicine may add to the already compassionate role of physicians with their patients because, as we all know but some of us may want to ignore, women tend to be a little more compassionate and nurturing than men. But that's not going to change the quality or the outcome as far as good medicine is concerned.

There's no way to know what's going to happen, but perhaps in the initial few years of women in medical practice you'll see more shared time in offices so that there's a little more time allowed at home for child care. One of the things the AMA's Women in Medicine Panel has been encouraging is shared residencies, meaning part-time rather than full-time hours. We've also been encouraging staggered starts in the residency programs, meaning some programs start later and could accommodate childbirth or child rearing. Some husbands are taking more responsibility in child rearing, so from that standpoint, both sexes are interested in shared starts and shared residencies. That might carry over into the first few years of practice. Women might be more interested in going into positions where they could have part-time work for a few years and then move into full-time work.

Some women may be insulted at my response because perhaps they're not interested in that. But with a working mother, it doesn't

matter in what profession, every couple solves the problem of good child care a different way, whether it's she or her husband or a good employee or a family member giving the care. Depending upon what comes out of Congress, we may also see a pattern toward more employed physicians. And if we get more employed physicians, we're going to get hours that are limited. You're not going to see the hours that most physicians work these days.

I can see only gains by having more women physicians. Women have to be aware of the role of family, of family responsibility, of physician responsibility and, as with men, community responsibilities. I would think that by having women we're going to see an increase in, or at least no less an awareness of, the needs to coordinate family, profession and community responsibilities. And who's going to benefit from that? The patients. Because surely physicians will be able to better understand the problems patients are bringing to them that relate to coping with all of these responsibilities. And as men and women physicians nurture and learn,



we'll be able to share this with our patients.

INDIANA MEDICINE: What effect will the increasing number of women physicians have on women's health issues?

Khalouf: We're already seeing an increased interest in women's health issues because of more women physicians and also because those women physicians and other active women are verbalizing the need for more interest in women's health issues. One example is the need for more research and more awareness of heart disease in women. Another example is the controversy over

mammographies and when they should be done and when they shouldn't be done. The other thing I'm seeing is an interest in having a women's health core curriculum at the medical school level, making medical students more aware of women's health needs within their medical school training. □

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The author is a health care communications consultant in Indianapolis.



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Telemedicine changing practice of medicine

Bob Carlson
Indianapolis

Physicians who travel the information superhighway are on the right road. Current interest in the info highway rivals that in health system reform. And that's no coincidence. Together, these two megatrends are going to dominate a huge chunk of our future. Those who aren't up to speed on either issue will be left behind.

Information. Super! Highway?

Information superhighway could be the most overused metaphor of the 90s, along with synonyms such as IT (information technology), I-way, I-bahn (as in Autobahn) or just plain old wired world.

What is it?

According to Microsoft co-founder Paul Allen, what we're talking about is "the marriage of video technology, computer technology and networking. That's the core convergence of ideas for the information superhighway." (*Fortune*, July 11, 1994:68) Investing \$750 million of his Microsoft loot in more than a dozen high-tech companies makes Allen one of the more high-profile developers of products and services for the highway. Some other players with more recognizable names are AT&T, Silicon Graphics, Zenith, the "baby" Bells (Southern Bell, Ameritech, Southwestern Bell, etc.), Apple Computer, Time Warner, Turner Broadcasting, Philips, Intel, CNN, Novell, IBM, Pacific Gas & Electric, Motorola,

McCaw Cellular, etc. You get the idea.

The call of the information superhighway is so alluring, and the prospect of being out of the loop so unthinkable, that every state in the Union is busily building its piece of the interstate I-way.

What does it all mean?

It means a networked economy driven by information technology. McLuhan's global village. Videoconferencing. Interactive merchandising. Maybe even virtual reality.

If you're in health care, it means telemedicine.

What is telemedicine?

Not long ago, processing your patients' insurance claims electronically and getting credited electronically was cutting edge. By the broad definition below, it even qualifies as telemedicine. But don't try to impress anyone with that now.

State of the art telemedicine in 1994 means live, full color, two-way video, two-way audio communication, across distances, between health care provider and patient or between health care providers.

In its broadest sense, telemedicine includes the communication of information in the areas of radiology, dermatology, pathology, cardiology, psychiatry, pharmacology, consultation, administration, medical records, billing, research, credentialing, utilization, medical education and patient education. Telemedicine moves information instead of people.

Telemedicine on agenda

How will telemedicine affect the future of medicine? Find out during a special program titled "Health Care 2000: What's Ahead in Reform & Technology" that will be held Saturday, Oct. 22, during the annual ISMA convention. For more details on this program, see page 382. □

These definitions, like telemedicine, are evolving. Fast.

According to Ameritech Health Care Marketing Manager Fred Kaiser, health care lags behind other industries in its use of telecommunications as a strategic and competitive weapon.

It looks as if health care is about to catch up.

Telemedicine's capabilities

Right now, telemedicine is being used for diagnosis, medical consultation, CME, patient education and administration. Soon, it will be used to make electronic house calls. As Francis Tedesco, M.D., president of the Medical College of Georgia, observes, "The limitations will be in our mind, not in the technology."

With telemedicine, almost any diagnostic procedure except palpation can be done remotely. Examination devices are redesigned for telemedicine applications or fitted with appropriate couplers so that a cardiologist can listen to



Photo by Shawn Spence

Ben Harmon, M.D., a radiologist at Methodist Hospital in Indianapolis, examines an ultrasound via a telemedicine link between the hospital and a health center 7 miles away.

a patient's heart and lung sounds, review the chest X-ray, electrocardiogram and cardiac ultrasound. An ophthalmologist can look inside the eye. An otolaryngologist can examine the interior of ears, nose and throat. A gastroenterologist can look into the patient's stomach or do a colonoscopy. An orthopaedist can do arthroscopy. A pathologist can review a specimen.

"This is all off the shelf technology," says Jay Sanders, M.D., professor of medicine and surgery at the Medical College of Georgia and director of MCG's Telemedicine Center. "Think of it as a gastroenterologist at a teaching hospital doing a gastroscopy with the fellows and residents watching the procedure on a big TV screen in the room. With

telemedicine, instead of being in the room, the TV screen is a thousand miles away."

With the ability to zoom in on an image, telemedicine can actually provide greater detail than direct examination. The tympanic membrane, for example, can fill an entire video monitor.

Two-way audio/video consultation between primary care physician and consulting specialty physician and between primary care physician and patient is experiencing especially rapid growth, according to Kaiser. "They're using it for pre-op and post-op consultation with patients at the Carle Clinic in Illinois."

Telemedicine here and now
Telemedicine's potential for revitalizing rural health care, for re-

ducing health care costs and for preventing disease is so enormous, there's not a state in the Union without some sort of telemedicine capability or a telemedicine demonstration project.

Distance is no deterrent to the technology. In Mogadishu, Somalia, the U.S. Army's 86th Evacuation Hospital, in collaboration with Walter Reed Army Medical Center, used telemedicine to provide care for soldiers and civilians.

Here are case studies from three locations, Georgia, Texas and Montana. Telemedicine practitioners talk about the benefits and the challenges of this revolutionary new health care delivery system.

Hubs and spokes in Georgia

"Georgia is leading the operational introduction of telemedicine in the United States today," asserts Dr. Sanders.

His involvement with telemedicine began 27 years ago when he worked with Kenneth Bird, M.D., on the Massachusetts General Hospital-Logan Airport telemedicine project. "I recognized his idea was a good one," he says, "even though initially I thought it was crazy."

Dr. Sanders ascribes Georgia's success with telemedicine to strong commitments by Gov. Zell Miller, the legislature, the president of the Medical College of Georgia, big businesses such as Southern Bell and Georgia Power, and the community into which telemedicine was first placed in 1991. That community was Eastman, about 150 miles from the first hub, the Medical College of Georgia in Augusta. Almost the



Jane Preston, M.D., Austin, Texas, is president of the American Telemedical Association.

entire state is now covered with 60 telemedicine sites configured in a hub and spoke pattern.

Georgia's telemedicine network includes two tertiary care academic medical centers and nine community hospitals, with the balance consisting of primary care rural hospitals, primary care clinics and public health facilities. This communication infrastructure allows a patient anywhere in the state to be examined by a physician anywhere in the state.

"The economics of telemedicine have demonstrated a very interesting situation," says Dr. Sanders. "Telemedicine allows a rural physician to keep a patient in his rural community. The revenue for taking care of the patient stays with that physician and with the rural hospital. Increasing the bed census for a rural hospital by a single patient, from 20 patients per day per year to 21 patients per day per year, represents a net cash flow increase of \$150,000 per year for that rural

hospital administrator." Initial figures indicate that about 85% of the patients who were previously transferred are now being retained in the rural hospital.

"If I put you in a rural hospital bed in Georgia today," Dr. Sanders continues, "your average per day cost is \$800. If I transfer you to see a dermatologist at the Medical College of Georgia, your per day cost is \$1,300, a \$500 a day differential. And that does not include the cost of transportation, or your loss of productivity, or the cost of delaying your therapy. So you are increasing the revenue within the rural community and you're decreasing the overall cost to the patient and to whoever is paying the bill." Dr. Sanders says that using telemedicine not only decreases net referrals from rural hospitals but also increases referrals to the "hub" hospital with telemedicine capabilities.

Because physicians can consult with their colleagues on the network and participate interactively in CME, telemedicine can mitigate the professional isolation many rural physicians feel. Dr. Sanders sees the benefits of videoconferencing flowing the other way, too. "Perhaps as important is getting rid of the professional isolation of the academic physician. If I had to set up a practice in a rural community tomorrow, I wouldn't have the slightest idea how to do that or what kind of patient population I might be dealing with. Yet I'm the one who trains that young physician. So when we talk about professional isolation, there are two sides to that coin."

From the beginning, says Dr. Sanders, he has emphasized that

Georgia's telecommunication infrastructure must serve not just telemedicine but all kinds of advanced communication needs such as business, banking, shopping and distance education. The two driving forces in building Georgia's I-way, according to Dr. Sanders, are distance learning and telemedicine. The distance learning network will soon be used for interactive preventive health care programming between the MCG Department of Pediatrics and classrooms in kindergarten through grade 12 throughout the state.

What's next? "We are about to deploy our telemedicine functionality into selected patients' homes," says Dr. Sanders. "It's called the electronic house call or the home health care network." Coaxial cable, the kind that brings cable television into the home, can readily be made bi-directional. Connecting a small video camera to the television or personal computer creates an interactive video system. Also connecting instruments like an EKG, an electronic stethoscope, a digital blood pressure cuff, a Doppler and a pulse oxymeter makes it possible to assess chronically ill patients on a regular basis without admitting them to a hospital. "When they turn their TV to the electronic house call channel, they're going to be seen and examined by their physician," says Dr. Sanders. "If we avoid a single hospitalization, that's an average saving of \$25,000. If this system works as we think it will, it will change the way we deliver health care in this country."

The Texas Telemedicine Project
"I grew up in a medical family in the panhandle of Texas. I made

Teleradiology benefits patients and doctors

Parkview Memorial Hospital in Fort Wayne is the hub for a regional teleradiology model. Radiologists read images from not only Parkview but also from area community hospitals that are linked electronically by a telecommunications network to Parkview.

The technology involves the use of a picture archiving and communications system (PACS), Kodak's Ektascan Imagelink.

The system links Parkview with four hospitals within a 100-mile radius: Cameron Hospital in Angola, Whitley County Memorial Hospital in Columbia City, Hicksville (Ohio) Hospital and Defiance (Ohio) Hospital and Clinic. Although a radiologist from

Fort Wayne Radiology Associates is on duty at the outlying hospitals during weekdays, coverage late at night and on weekends has long presented a problem. In some cases, the hospitals might have waited until the next morning for a reading. And in the past, either the film had to be transported to a radiologist or vice versa.

Now that's unnecessary. Each hospital can digitize images from a critically ill patient, telecommunicate them to Parkview over telephone lines in less than five minutes and get an immediate reading from a radiologist.

"In the case of a head injury, we used to transport the patient immediately to Parkview for treatment because it would take too long for us to determine if the injury was critical. We lost the

ability to treat patients here, as well as the revenue they represent," says Richard Palmer, director of radiology at Whitley County Hospital.

The system benefits the radiology group too. Donald Sugarman, M.D., a partner in Fort Wayne Radiology Associates, says it eliminates a drive to the hospital by a radiologist and allows the group to implement a one-person, after-hours call system at Parkview.

Patients benefit the most however. The diagnostic cycle is shortened, and treatment that might have waited hours can begin immediately.

Cost savings are projected to be more than \$480,000 during the second year of use and rise slowly to \$590,000 in the seventh year. □



Donald Sugarman, M.D., center, of Fort Wayne Radiology Associates discusses image quality on the Ektascan Imagelink system with Eldon E. Taylor, R.T., left, and Dennis Warner, director of radiology at Fort Wayne's Parkview Hospital.

rounds with my uncle by car, and sometimes we drove up to 150 miles in an afternoon to see patients on their farms. I understand the price of not being able to get to people," says Jane Preston, M.D.

Back in the mid 1950s, when she was on the staff of a hospital in Newfoundland, Dr. Preston recalls setting up a telephone system for diabetic rounds in distant towns that were iced in most of the year. Today, she is the president of the American Telemedicine Association and director of the Texas Telemedicine Project, headquartered in Austin.

Her interest in telemedicine was triggered by the STARPAHC (Space Technology Applied to Rural Papago Advanced Health Care) project, which provided health care services to a remote Indian reservation in Arizona and valuable data to NASA for future manned space flight. By the late 1980s, says Dr. Preston, she was reasonably sure telemedicine could be cost-effective if planned properly. "We looked for the state that had lost the most rural hospitals, and it turned out to be my state, Texas. So we decided it would be good to do it here. The Texas Telemedicine Project was set up to answer a number of questions in a living laboratory, you might say."

Chief among those questions was whether telemedicine could be cost-effective if planned properly. In 1988, she formed a not-for-profit corporation, Telemedical Interactive Consultative Services, Inc. (TICS), to finance, organize, manage and monitor the Texas Telemedicine Project. "I decided to do it without state or federal funds so I could report whatever I

found. I was able to raise family foundation money for the management, and Southwestern Bell and GTE gave the lines," says Dr. Preston.

The project became operational in 1991. Three sites in Austin – Austin Diagnostic Clinic, Austin State Hospital and the Texas Youth Commission – provide medical and psychiatric services to four institutions in Giddings, a small town 65 miles away – Lee Memorial Hospital, Lee County Mental Health Clinic, Giddings Regional Dialysis Center and the Giddings State School.

Specialty consultations available on the network include cardiology, rheumatology, neurology, pulmonology, urology, nephrology, allergy, dermatology and psychiatry. After one year of operation, the numbers showed that the project could pay for itself in only 2.6 years. "Can Telecommunications Help Solve America's Health Care Problems?" an often-quoted 1992 Arthur D. Little study of the Texas Telemedicine Project and other telemedicine initiatives, projected nationwide health care savings of \$36 billion.

In 1992, Dr. Preston founded the American Telemedicine Association, which has become, in her words, "something of a voice for telemedicine." The ATA Board of Directors is a virtual "Who's Who" of telemedicine in America today. Dr. Preston has also written *The Telemedicine Handbook*, an information-packed, definitive work in which she shares her comprehensive knowledge of telemedicine.

"The most important thing I can think of is to get some guidance about how to set up a telemedicine network," counsels

Dr. Preston. "You can't find out about a network from a point-to-point system. The figures are very misleading."

What about the limitations of telemedicine?

"I think it's very important that doctors follow the same rules they've always followed. In surgery it's expressed as 'don't cut where you can't see.' If you can't understand what's going on, have the patient brought in. Thus far, my observation is that doctors using telemedicine practice the way they always have, with the focus on the patient and the patient problem. I haven't seen any overextending at all," says Dr. Preston.

The Eastern Montana Telemedicine Network

"I lived in Alaska. I worked up there in a community as a sole provider 650 miles from the nearest hospital or physician for a year. That's where I got my appreciation for what this technology will do," says Jim Reid, PA-C (Physician Assistant-Certified), principal developer and former director of the Eastern Montana Telemedicine Network (EMTN). He recently left that position to become a full-time telemedicine consultant.

The EMTN is based at the Deaconess Medical Center (DMC) in Billings, the largest city in a 500-mile radius, and consists of six sites, one urban and five rural. Four of the rural sites are hospitals and one is a community mental health center with outpatient services. Each remote facility is staffed by one or more part-time site facilitators.

DMC is a 272-bed tertiary care medical center and operates a

number of programs to address the problems of rural health care delivery and to support the primary care providers in its service area, which includes eastern Montana, northern Wyoming and the western Dakotas. The EMTN was conceived and developed as another outreach program designed to meet the needs of the rural communities DMC serves.

Telemedicine services delivered over the EMTN include patient care during scheduled specialist telemedicine clinics; consultations requested by rural primary care or mental health professionals; routine and emergency x-ray interpretation; and consultative interpretation of pathology slides, endoscopies, echocardiograms, electrocardiograms and other medical imaging.

Because Montana does not have a medical school or residency program, there is also the potential to benefit from links between the EMTN and large academic institutions such as the Mayo Clinic, the University of Kansas Medical Center or the Medical College of Georgia. Any site on the EMTN can be linked with any of these institutions.

In addition to telemedicine, the network provides three other categories of services: mental health consultation, continuing medical and higher education and community development applications. The latter category includes a variety of users such as businesses and community organizations. The EMTN is the first telemedicine project to integrate multiple use applications. "The intent is to spread the cost of the network and the operating costs over a broad enough base so that it's cost-effective for individual

end users," says Reid.

While a formal evaluation of the EMTN in cooperation with the University of Montana Business and Economic Research Department is still in progress, Reid shared some preliminary impressions.

"In the long term," says Reid, "I think telemedicine will prove to be an effective, safe and cost-saving way to deliver health care services because it's cheaper to provide those services in the rural community. And that is why managed care will drive this technology. The primary care provider, or gatekeeper, stays in control, more services are provided locally, tests are not duplicated, and when a referral is absolutely necessary, it's to the right specialist the first time because the sorting out has already been done by videoconferencing. Overall, you're getting the biggest bang for the buck."

How have rural physicians taken to the EMTN?

"Most physicians are initially quite resistant to it," admits Reid. "Some warm up and some don't. It's a new and very different way of doing things. It's far easier for a rural physician to say 'I don't know. I'm sending you to a specialist,' and they're done. Others would much rather continue to be involved in the patient's care and participate in the telemedicine consult. Some rural physicians resist telemedicine because they feel it's an intrusion on their territory by the urban tertiary care center. In fact, a study in Norway has shown that primary care providers who use telemedicine actually become more competent in managing things they used to refer out."

Sources for more information

More information on telemedicine is available from the following sources:

Jane Preston, M.D.
President
American Telemedicine
Association
1700 One American Center
600 Congress Ave.
Austin, TX 78701
(512) 480-2247

Jim Reid, PA-C
Innovative Medical
Communications
P.O. Box 80691
Billings, MT 59108-0691
(406) 698-6855

Marv Sacks
Director, External Relations
Ameritech Indiana
240 N. Meridian St., Room 954
Indianapolis, IN 46204
(317) 265-2567

Jay Sanders, M.D.
Director
Medical College of Georgia
Telemedicine Center
1120 15th St., Building EA
Augusta, GA 30912-1655
(706) 721-6616 □

What about patient acceptance?

"Well over 50% indicate that something is missing from the patient-physician visit when it's done by telemedicine," says Reid. "However, 100% of the same respondents indicate that they

would rather have another telemedicine visit than have to travel to see the physician. They're able to gauge the payoff real quick. With telemedicine, the patient is always a winner. The patient always saves. For example, Culbertson, which is the smallest community on our network and the furthest away from Billings, is the greatest user of the network. It's real clear that every patient who is seen over the network saves between \$400 and \$550 every visit in mileage, lodging, meal expenses and lost wages. If our health care system paid for that, this technology would be in place everywhere."

The trials of telemedicine

"We don't in general cover telemedicine services under Medicare," says Helen Smits, M.D., deputy director of the Health Care Financing Administration (HCFA) in Washington, D.C. "Any payment for telemedicine is being made on a demonstration basis pending information to make future decisions about. We do have a variety of demonstrations going to look at whether we ought to pay and under what circumstances and how much."

At this time, according to Dr. Smits, Georgia physicians are receiving reimbursement for telemedicine services "through an arrangement with the Medicare carrier." In the Texas Telemedicine Project, says Dr. Preston, "None of our doctors received any money." In Montana, Jim Reid says Medicare's current policy against reimbursing for telemedicine services is "extremely unfortunate."

Dr. Smits says it's hard to say, but that the demonstration phase

"usually takes some years with something this different." HCFA is providing funding to evaluate telemedicine demonstrations in a number of states including Georgia, West Virginia, North Carolina and Iowa. "Rather than us trying to decide or the site trying to decide, you hire an evaluator, you ask someone objective to look at it, to treat it like an experiment and to look at what can be learned from it. Some of that's done by private consulting firms, some by academic health centers," says Dr. Smits.

What sorts of things are evaluated?

"Cost-effectiveness, patient acceptance, whether the quality of the care appears to be at least equal to the care given in more conventional ways. All the things you'd want to know before you'd start getting all your medical care through telemedicine," says Dr. Smits. "I've been very impressed about how enthusiastic doctors have been, particularly in remote rural sites, about telemedicine's ability to provide them with those kinds of support that they just haven't been able to have before."

"I'm looking forward to what they're going to tell me. One of the big issues is how well physicians accept it, how comfortable they feel with it in the long haul," she added. "There are some physicians that are very enthusiastic about telemedicine, and we're looking forward to seeing if that's generalizable."

Opportunity Indiana

"Opportunity Indiana accelerates the development of an advanced communication system, including fiber optics, for links throughout the state in Ameritech's service

areas for hospitals, schools and major government centers," says Marv Sacks, director of external relations for Ameritech Indiana. "From the standpoint that hospitals are going to be one of the first to link up with this infrastructure, it is a tremendous benefit to health care."

The Indiana Utility Regulatory Commission approved Ameritech's Opportunity Indiana Plan in early July of this year. Opportunity Indiana calls for Ameritech to spend \$120 million on communications infrastructure within the state, plus another \$30 million on training and equipment for schools. According to Sacks, an implementation plan with more details will be ready in October of this year.

"Opportunity Indiana basically brings the information superhighway to Indiana," says Ameritech's Kaiser. While fiber optic transmission lines are the transport medium of choice for applications like telemedicine, "it all depends on what you want to do," according to Kaiser.

Donald Sugarman, M.D., of Fort Wayne Radiology Associates, for example, has been using a picture archiving and communications (PACS) system to receive and transmit digital images at Parkview Memorial Hospital in Fort Wayne since 1985. During this time, Parkview has become the hub for a regional electronic teleradiology network including four other hospitals. (See story on page 355).

St. Vincent Hospital in Indianapolis has been using existing telecommunications infrastructure for videoconferencing, primarily for administrative and consultative purposes. St. Vincent cardi-

ologists have teleconferenced with physicians in Indonesia to determine how effectively 2-D echocardiograms and heart catheterization films can be relayed using existing technology. "Down the road," says Alan Handt, M.D., senior vice president of medical affairs, "we envision a system that will enable us to link up real-time not only with other Indiana physicians but also with hospitals and physicians worldwide to provide diagnostic and treatment support."

How soon can Indiana physicians do telemedicine?

"As soon as they're ready to sign up for the service with Ameritech," says Kaiser. "The systems and the facilities are available to make that happen now. The costs have come down dramatically over the last four to five years, and they're continuing to go down. For those who are willing to make the jump into telemedicine, we can help them do that today."

Ben Harmon, M.D., has already made the jump.

Capturing market share

"I went to Ameritech and talked to some of the technical people in their lab and drew pictures on chalkboards and explained what I do and how I do it. We came up with this idea of using the existing fiber optic network in the city," recalls Dr. Harmon, a radiologist at Methodist Hospital in Indianapolis. About eight months ago, his idea became the city's first interactive, real-time teleultrasound trial project. He hasn't looked back since.

Dr. Harmon specializes in ultrasound, CT and MRI, with a particular interest in ultrasound. The telemedicine link is between

Methodist Hospital, where Harmon is, and the Glendale Metro Health Center, where his patient is, about 8 miles away. Harmon directs the movement of the ultrasound transducer via a two-way video and telephone link with the technologist performing the procedure on the patient.

"I see the same image on my monitor as it is being generated by the ultrasound machine at the same time as the tech sees it at the remote site," says Dr. Harmon. "Unlike chest x-rays, ultrasound is a very dynamic modality. Where you put the transducer, is the baby moving? is the heart moving? — all that information is critical to the study."

Before this trial project, a technologist would videotape the ultrasound at one of the satellite clinics and deliver the tape to Methodist for analysis. After a three-day wait, the patient received the results. "Now I just explain to the patient and the doctor exactly what's going on, as it's going on," says Dr. Harmon.

Another advantage is that it's easy to monitor problem cases. Of the 800 telemedicine procedures he has done so far, treatment has been expedited for several patients with ectopic pregnancies or other severe conditions that would have required admittance to the emergency department or a stat ultrasound at night. He says that has resulted in definite cost savings.

Dr. Harmon, who admits to having a strong business feel for medicine, says he is very aggressive about what the Methodist radiology group should be doing. "With this technology, I can project myself electronically to other places without having to drive anywhere," he says. "The

coverage I give them is equal or sometimes even better than what I do in the hospital. The more cases I can read, the more lives are in my contracts, the more competitive I will be in the new market. This is the way of the future, and if you don't watch out, pretty soon I'll have the whole market."

Telemedicine here to stay

Imagine having to demonstrate, with carefully collected data, the cost benefits of using the telephone in your practice; the impact of the telephone on the quality of the care you deliver; patient acceptance of the telephone.

But the benefits of the telephone are obvious, you're probably thinking. Telemedicine is nothing more than the marriage of telephone, television and computer — all technology we take for granted.

"Telemedicine is here to stay," says Reid. "You should investigate it. You should get your hands on it. You should play with it. You should become familiar with it because it's the way you're going to be doing things."

Reid likes to quote these words by Marshall McLuhan in his lectures on telemedicine: "The future masters of technology will have to be lighthearted and intelligent. The machine easily masters the dumb and the grim." □

The author is a health care communications consultant in Indianapolis.

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Stark outlook for physician self-referrals

Norman G. Tabler Jr.
Rolanda Moore Haycox
Indianapolis

The promise of a newly reformed health care system has already resulted in significant restrictions on the way medical care is provided. Among the most severe restrictions are the recently enacted anti-referral provisions of the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II."

Stark II extends the provisions of a statute known as the Stark Act, which prohibits a physician from referring Medicare patients in need of clinical laboratory services to any entity with which the physician or a member of the physician's immediate family has a financial relationship and prohibits the submission of claims for services resulting from such referrals. Stark II broadens these prohibitions by making them applicable to referrals for the furnishing of all "designated health services" otherwise payable by Medicare or Medicaid.

Under Stark II, which becomes effective Jan. 1, 1995, designated health services include:

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- radiology and other diagnostic services;
- radiation therapy services;
- durable medical equipment;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics and prosthetic devices;
- home health services;
- outpatient prescription drugs;

and

- inpatient and outpatient hospital.

The term "designated health services" is not synonymous with the term "ancillary services," although there is considerable overlap. No ancillary service is a designated health service unless it is on the list shown above, and if a service is not a designated health service, the new law will not apply to it. On the other hand, the term "designated health services" is in some respects broader than the term "ancillary services" because it includes all inpatient and all outpatient hospital services.

Stark II is applicable when one of two basic types of financial relationships is maintained between a referring physician and an entity that provides designated health services. A financial relationship exists if a physician has either an ownership or investment interest in an entity providing designated health services or a compensation arrangement with the entity.

The ownership interests covered by Stark II include all ownership or investment interests that may be established through equity, debt or other means as well as indirect ownership interests, such as an ownership or investment interest held by a physician in an entity that itself holds an ownership or investment interest in an entity that provides designated health services. As an example, if a physician has an investment interest in a home health services agency and that agency has an ownership interest in a durable medical equipment company, the physician may be pro-

hibited from referring patients to both the home health services agency and the durable medical equipment company.

The compensation arrangements covered by Stark II include all arrangements involving direct or indirect remuneration between a physician and an entity providing designated health services, even if the remuneration is not related to the provision of designated health services. The statute also covers arrangements in which a physician compensates an entity providing designated health services if the compensation is not for the provision of items or services by the entity at a price consistent with fair market value.

The number of arrangements that may be "compensation arrangements" under Stark II is almost unlimited. For example, if a physician group owns a building and a tenant pays rent and utility costs, that arrangement constitutes a compensation arrangement. If the tenant provides any health services listed above, then the physician group has a compensation arrangement with an entity providing designated health services. As another example, a compensation arrangement may exist when a physician provides free or discounted services to another entity or when an entity provides them to a physician.

Because Stark II covers a broad range of financial relationships, including relationships that do not involve monetary compensation, the effects of the statute must be analyzed in connection with every arrangement between a physician and an entity that

provides designated health services. Furthermore, because Stark II is effective for referrals for clinical laboratory services made on or after Jan. 1, 1992, and referrals for all designated health services made after Dec. 31, 1994, physicians who have an ownership interest in, or compensation arrangement with, an entity providing a designated health service may need to make other arrangements for their patients before the beginning of 1995.

Escaping the prohibitions

Stark II contains a number of exceptions, including general exceptions and exceptions that are applicable solely to ownership and investment interests or solely to compensation arrangements. The exceptions to Stark II that are most likely to provide protection for physicians referring patients for outpatient services are the general exceptions for physicians' services and in-office ancillary services. The location and billing practices of the entity providing the designated health services and the ability of the physician practice group to qualify as a "group practice" are key elements of these exceptions.

Under Stark II, a group practice is a group of two or more physicians organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan or similar association with all the following characteristics:

- Each physician provides sub-

stantially the full range of services the physician routinely provides through the joint use of shared office space, facilities, equipment and personnel;

- Substantially all of the services rendered by the group are billed using the group's billing number;
- Receipts for amounts billed are treated as receipts of the group;
- Overhead expenses and income are distributed in accordance with previously determined methods;
- No member of the group receives compensation directly or indirectly based on the volume or value of referrals by the physician (except that a physician may be paid a share of the group's profits or a

are patients of the group, rather than patients of any individual physician claiming to be a member of the group. This requirement is aimed at discouraging physicians with independent practices from declaring themselves to be a group practice without actually pooling their patient populations.

The determination of whether a physician group is a group practice is extremely important in applying the exception for physicians' services. This exception provides that services such as surgery, consultation and office visits are not subject to the Stark II prohibitions, provided they are performed personally by, or under the supervision of, another physician in the same group practice. For example, this exception

is applicable to a situation in which an internist who is a member of a multispecialty group practice refers a patient to another physician within the group for an outpatient biopsy procedure.

For certain

other referrals within a group practice, the exception for in-office ancillary services also provides a means of escape from the Stark II prohibitions. This exception is applicable if the designated health services:

- 1) are personally performed by the physician, by another physician in the same group practice, or by an individual supervised by the physician or another physician in the same group practice; and
- productivity bonus based on services personally performed by the physician if the amount of the share or bonus is not determined in a manner directly related to the volume or value of referrals by the physician); and
- Members of the group personally conduct no less than 75% of the group's physician-patient encounters. In other words, 75% of the patients seen by the group collectively

The exceptions to Stark II that are most likely to provide protection for physicians referring patients for outpatient services are the general exceptions for physicians' services and in-office ancillary services.

- 2a) are provided in the same building in which the referring physician or another member of the same group practice furnishes physicians' services unrelated to the furnishing of designated health services, or
- 2b) are provided in a building used by the group practice for the provision of some or all of the group's clinical laboratory services or for the centralized location of the group's designated health services other than clinical laboratory services; and
- 3) are billed by the physician performing or supervising the services, by the physician's group practice under the billing number assigned to the group practice or by an entity wholly owned by the physician or the physician's group practice.

In general, the in-office ancillary services exception protects referrals by physicians who provide clinical laboratory or diagnostic imaging services within their offices and referrals by members of a group practice that has centralized the designated health services provided to its patients. For example, a group practice that provides diagnostic imaging services within the same office suite used for patient visits, that supervises the non-physician personnel operating the equipment, and that bills for the service will not be subject to the Stark II prohibitions. On the other hand, a physician who invests in an outpatient pharmacy and who refers his patients who need prescription drugs to the pharmacy will not be covered by the exception.

Other exceptions may also apply, depending upon the circumstances of the arrangement. For example, a physician may

lease part of his or her office building to a radiologist operating a small mammography center and may also refer patients to the center. Assuming that no other financial relationship exists between the physician and the mammography center, these referrals will not be prohibited, provided the lease is:

- 1) commercially reasonable;
- 2) has a term of at least one year;
- 3) is for space that is no more than what is reasonable and necessary for the legitimate business purpose of the lease; and
- 4) is consistent with the fair rental value of the property without consideration of the volume or value of referrals and without exceeding the tenant's pro rata share of expenses for the rental of any common space.

A physician may also enter a contract for the provision of designated health services, such as physical therapy services, without violating the statute, provided the contract is in writing, covers all the services to be provided, is for a period of at least one year and is consistent with the physician's reasonable and legitimate business needs and the fair market value of the services.

Planning for the future

Physician groups that do not meet the definition of a group practice may have difficulty conforming to the criteria of an exception that might otherwise be applicable to a given arrangement with an entity providing designated health services. For example, a physician group that does not qualify as a group practice will not qualify for the exception for in-office ancillary services unless several conditions are met:

- 1) the physician performing the

service is the referring physician;

- 2) that physician performs or personally supervises the service;
- 3) the services are performed in a building in which the physician provides unrelated services; and
- 4) the physician bills for the services under his own billing number.

On the other hand, because individual practitioners who perform designated health services in their own offices are likely to perform and bill for the services, they may be more likely to meet the in-office ancillary services exception and to avoid the Stark II prohibitions.

To determine whether the Stark II prohibitions are applicable to an arrangement between a physician and an entity providing designated health services, several questions must be answered. The answers must then be looked at as a whole to determine whether the physician maintains an ownership interest in or compensation arrangement with an entity providing designated health services to which he or she refers patients and, if so, whether the investment interest or compensation arrangement falls within an exception to the Stark II prohibitions.

Some key questions for initiating an analysis under Stark II include the following:

- 1) Case mix – Does the physician refer Medicare and Medicaid patients to the entity?
- 2) Provider – Who performs the service? If not the referring physician or another physician within the referring physician's group practice, who supervises the individual who performs the service?
- 3) Location – Where is the entity located? If the entity is lo-

cated in the same building as the physician's office, what types of services does the physician provide that may be unrelated to the designated health service? If the entity is located in another building, what percentage of the designated health services for the group practice does the entity provide?

- 4) Billing – Who bills for the designated health services provided by the entity? Whose billing number is used?
- 5) Payment – What type of payments, if any, are made between the entity and the physician? What is the basis for

these payments?

- 6) Agreements – Does the physician have any written agreements with the entity or any individual who owns or operates the entity?
- 7) Indirect ownership – Does the entity or any of its owners have an ownership or investment interest in another entity to which the physician refers patients?

The answers to these questions will provide a starting point for the physician and his or her legal counsel to determine whether the physician may refer patients to the entity providing designated health services without violating the Stark II prohibitions.

These arrangements should be evaluated so plans can be made to correct problems before the end of 1994.

For many physicians, the outlook for 1995 may be Stark. □

The authors are attorneys in the Indianapolis office of the law firm of Baker & Daniels. As part of that firm's health care department, they represent physicians, physician groups and other health care providers.

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Case study analysis of physician hospital organizations

Editor's Note: This article is the executive summary of a study on physician hospital organizations.

Thomas M. Gorey, J.D.
Crystal Lake, Ill.

In response to the growing interest in physician hospital organizations (PHOs), the American Medical Association, the Illinois State Medical Society, the Indiana State Medical Association and the Michigan State Medical Society agreed to co-sponsor a study of PHOs and the physician organizations (POs) associated with them.

The sponsors agreed that the best way to obtain the desired information on PHOs would be to acquire it directly from those who were involved in the formation and ongoing operation of PHOs, via a series of PHO case studies which would have a primarily qualitative, rather than quantitative, focus.

The undertaking of this study does not represent an endorsement of the PHO concept or of managed care, but rather is part of organized medicine's ongoing effort to communicate to its members timely information concerning significant changes in the organization, delivery and financing of health care services. PHOs are only one of a number of models that may warrant consideration by physicians as part of their long-range strategic planning. An examination of other models is being undertaken through a separate study, which will provide information and analyses on the physician equity model, the "group without walls" approach and

other physician integration strategies.

Role of POs in PHOs

The importance of a PO in the formation and ongoing operation of a PHO was confirmed throughout this study. Repeatedly, in discussions with physician and hospital representatives of PHOs that had a PO (six of the eight studied), the point was made as to the essential role played by the PO in all phases of PHO planning, development, operations and policymaking.

Those supporting the physician organization concept felt that a PO served an important role in: unifying the physicians; providing a structure and process for information sharing and policymaking; fostering physician consensus building and decision making; presenting a unified front in discussions with hospital representatives; and enhancing the ability of the PHO to negotiate with payers.

Physician leaders essential

A key ingredient in whatever success has been achieved to date in the POs and PHOs included in this study is the leadership role played by a handful of dedicated respected physicians. These physicians had a number of characteristics in common, including a clear vision of the role the PO and PHO could play in the changing health care delivery system and a sincere commitment to the concept of physicians working cooperatively with their hospital to further the goals of patients, physicians and hospitals. These physician leaders also had the trust and respect of the medical staff

and were willing to devote countless hours to the tasks associated with organizing and operating a PO and PHO.

An issue that affects most PHOs and is even more pronounced if there is a PO in place involves the relationship between the PHO (and PO if one exists) and the medical staff leadership. In some cases, PHOs have taken the approach that the medical staff is a completely separate entity that has little relevance to the business or policy operations of the PHO. As such, they have distanced themselves from the organized medical staff. In others, however, there has been a deliberate attempt to foster goodwill between the medical staff and the IPA by keeping the medical staff organization informed of PHO developments and involved in its activities.

Most PHO participants foresee significant long-term issues involving the hospital medical staff, including possible duplication of effort and conflict, particularly if PHOs and POs begin to take on some of the responsibilities currently assumed by the medical staff in such areas as credentialing and quality assurance.

Role of the hospital

Having a well-organized and focused group of physicians, with talented and motivated leaders, represents only half of the PHO equation. As important as it is that the physicians have leaders whom they trust and respect, it is equally critical that the hospital administration has the trust and respect of the medical staff. Al-

though the level of trust typically increases as the parties begin to work more closely together in a PHO arrangement, a certain level of trust must be present at the outset.

The hospital administration and hospital board must be committed to the PHO concept, including being willing to share control and decision making within a joint venture framework. The hospital CEO must have the interpersonal skills to be able to handle conflict constructively and to build consensus.

Measures of a hospital administration's commitment to a PHO include: the extent to which the hospital is pursuing conflicting strategies, such as purchasing primary care physician practices; the administration's willingness to utilize the PHO for all of the hospital's managed care contracting; and the willingness of the administration to sacrifice short-term financial gains for the long-term success of the hospital, the medical staff and the PHO.

In addition to having a hospital administration that is committed to the success of the PHO, there must be strong support for the PHO at the hospital board level, and the hospital board must understand the long-range implications of establishing a PHO. Bringing hospital board members into the PHO planning process at the earliest possible stage and giving them meaningful involvement in PHO decision making can enhance a PHO's potential for

success.

Role of physicians

The need for primary care physicians to play a prominent role in all phases of PHO development and operations was emphasized repeatedly by hospital CEOs and physicians alike. Several PHOs in this study were formed after earlier efforts spearheaded by specialists failed because they did not develop a managed care product that was attractive to business and other payers.

Two issues that surfaced consistently throughout the case studies were: 1) the need to address the balance between the number of primary care physicians and

sub-panels of physicians within the PHO, who would be eligible for participation in some, but not all, of the PHO's managed care contracts, is an option that many PHOs currently are considering.

Despite unanimous agreement among PHO representatives with the concept of empowering primary care physicians and providing them with a lead role in PO and PHO policymaking, most of those in this study have not established primary care-controlled governance structures.

Most PHOs have faced the issue of physicians of various specialties wanting to be considered primary care physicians. Although most PHOs have begun

to address the problem by adopting a definition of primary care that encompasses only family practice, general internal medicine and pediatrics, contentious issues between primary care physicians and specialists are likely to continue

in PHOs.

Information systems essential

If there was one comment that was made consistently by representatives of every organization included in this study, it was that having a good computer information system is essential to the success of PHOs. However, despite this recognition of the critical importance of management information systems, none of the PHOs in this study was completely satisfied with the systems that they had in place and virtually every PHO representative lamented the

In addition to having a hospital administration that is committed to the success of the PHO, there must be strong support for the PHO at the hospital board level, and the hospital board must understand the long-range implications of establishing a PHO.

specialists in the membership of POs and PHOs; and 2) the need to provide for a significant degree of primary care physician involvement in PO and PHO governance.

Currently, the specialty composition of PHOs tends to mirror quite closely the physician population as a whole, with most PHOs having roughly one-third primary care physicians and two-thirds specialists. While aggressively seeking to recruit and retain primary care physicians, most PHOs are addressing the issue of how to narrow their panel of specialists. The notion of creating

fact that the PHO had not moved more aggressively to put in place an adequate information system.

In particular, the concern was voiced that data collected by the hospital (or insurance companies) for claims and payment purposes may not be useful for purposes of analyzing physician practice patterns. Most PHOs indicated that they do not want to continue to be dependent on payers for data, because they feel that utilization data from payers often is not received in a timely manner, is too oriented toward inpatient care, or is compiled in unique ways by different payers, thereby decreasing its usefulness to the PHO as a utilization management tool.

PHO capitalization, management, operations

The amount of money invested by physicians and hospitals in PHO ventures varies considerably and is dependent primarily on the purposes for which the PHO is organized. The initial expenses of establishing a PHO are primarily for legal and consulting services and, for the PHOs in this study, these fees generally ranged from \$50,000 to \$150,000. Aside from these initial market analysis, strategic planning and organizational expenses, the two major sources of PHO expense involved a significant, one-time expense for development of a management information system and ongoing expenses for PHO administrative support (i.e., staff salaries and benefits). In most cases, the initial expenses to establish the PHO were dwarfed by the ongoing operational expenses, particularly if the PHO was involved in claims processing.

All of the PHOs in this study

were legally structured as 50-50 joint ventures between physicians and the hospital, but in practice, none of the PHOs actually was funded at the outset by a 50% capital contribution from the physicians. Although the specific details varied among PHOs, each offered some loan, letter of credit or other arrangement by which physicians could pay back their share of the initial capitalization over time.

Regardless of the number of staff, the point was made repeatedly as to the necessity of having knowledgeable dedicated staff who have a broad mix of technical and interpersonal skills and who are able to work effectively with the hospital administration and with physicians. PHO staff came from a variety of educational and professional backgrounds, but most had significant experience either with an insurance company, an HMO or a hospital.

Most of the PHOs in this study were legally organized as not-for-profit corporations, and representatives of these organizations repeatedly indicated that there was no expectation that the PHO itself would generate a surplus. Rather, the explicit goal of these PHOs was to preserve or expand the market share of the participating physicians and the hospital. However, several of the PHOs that were aggressively pursuing risk-based payment arrangements (or that were forming their own HMOs) clearly were seeking to realize significant financial returns for the PHO.

PHO contracting and payment arrangements

The types and numbers of contractual arrangements entered into

by the PHOs in this study varied considerably. On the low end, one of the PHOs had only two contracts, and on the high end, one of the PHOs had more than 30 payer contracts. The number of covered lives ranged from fewer than 5,000 for a relatively new PHO to more than 80,000 in the case of three of the more well-established PHOs in the study.

To a large extent, the type of contracting arrangements entered into by the PHO was a reflection of the type of market in which the PHO was located. PHOs in relatively low managed care markets, where PPOs were the predominant form of managed care, entered primarily or exclusively into discounted fee-for-service payment arrangements. PHOs located in high managed care markets typically had both PPO and HMO contracts, with a clear pattern toward growth in HMO and other risk-based contracts.

Most PHO representatives indicated that, if possible, it was best to begin with relatively simple, discounted fee-for-service contracting arrangements and gradually move toward more sophisticated risk-sharing contracts, as the PHO matures.

The PHOs in this study used a variety of physician and hospital payment approaches. For the most part, even if the PHO was accepting capitation payment from an HMO, the physicians were being paid primarily on a fee-for-service basis, often with a withhold. In several cases though, primary care physicians were being paid on a fixed, per member, per month basis, while specialists were paid based on a fee schedule. Most PHOs either have developed or are in the pro-

cess of developing their own physician fee schedule.

Currently, if physicians are "at risk" in PHO arrangements, it is typically through the use of withholds. However, most PHO representatives were not completely satisfied with withholds and agreed that, over time, mechanisms will be implemented to provide individual-based physician incentives.

The PHOs in this study differed in their ability to bind the physicians to the terms of PHO contracts. In some cases, the physicians had given the PHO the authority to enter into binding agreements with payers if the contracts met certain terms; in others, the physicians had an opportunity to "opt out" of any contract by notifying the PHO.

PHOs use several types of hospital payment arrangements, including per diems, DRGs and capitation. Although per diems were the most frequently used hospital payment mechanism, most of the PHO representatives indicated that, as with physicians, hospitals would be accepting more and more risk over time, first through case payment rates and eventually through fixed, per member, per month payment.

Although the potential for direct contracting with businesses is often held out as one of the major advantages of PHO arrangements, a number of the PHOs in this study were reluctant to enter into direct contracts with employers for fear of alienating the insurance companies and HMOs with whom the hospital or PHO currently has contracts. In other cases, however, direct contracting arrangements were the stimulus for the development of

the PHO, and the PHOs have pursued such arrangements seemingly without any adverse ramifications.

State insurance laws, which explicitly or implicitly limit the extent to which PHOs can accept risk, is another reason some PHOs have been reluctant to pursue direct contracting arrangements. Other PHOs have been more comfortable operating in the "gray area" that currently exists in most state insurance statutes.

Several of the PHOs in this study were involved in the development of an HMO, either through the PHO itself, through the hospital or through a consortium of PHOs or hospitals. Many of the PHOs in this study, however, had no plans of ever evolving into an HMO either because they had no interest in taking on that higher level of risk or, more often, because of the potentially negative impact this action would have on their existing relationships with other HMOs.

Shared decisionmaking

Inherent in the PHO concept is an assumption of shared physician/hospital decisionmaking. Without exception, the PHOs in this study confirm that assumption, with physician and hospital representatives having an equal voice in each of the PHOs studied. Although the size of the PHO governing boards ranged from a low of four to a high of 16 members, each provided for an equal number of physician and hospital representatives.

Of the eight PHOs studied, two provided for community or business representation on the PHO board. These PHOs spoke favorably of the contribution that

the community/business trustees have made to the success of the PHO.

"Supermajority" voting provisions, which require certain matters to be approved by a majority of the physician representatives and a majority of the hospital representatives on the PHO board, provided safeguards to the physicians and the hospital by eliminating the possibility that one party could use the governance process to dominate the other.

PHOs handled the issue of board leadership in various ways, including alternating between a physician and a hospital board chair and providing for co-chairs (one physician and one hospital representative).

PHO credentialing process

The PHO credentialing process, though separate from the hospital's in most cases and ostensibly geared to reflect market demand, usually involves similar procedures and criteria. In PHOs that have a physician organization, the PO typically has responsibility for credentialing, and physicians have to join the PO to be eligible to participate in the PHO. In PHOs without a PO, the PHO board establishes the credentialing criteria but usually with physicians playing an exclusive or lead role in the development of the criteria.

Most PHO representatives expressed the view that physician practice patterns will eventually become a more significant factor in the PHO credentialing, and especially recredentialing, process. Many saw this movement toward a more "closed" approach as being integral to the future success, and perhaps even viability, of

PHOs.

Most PHOs that have been in operation for more than a few years are struggling with the issue of how to make the PHO more selective. As these PHOs move increasingly toward capitation, they anticipate having to face the challenge of narrowing their panel to a smaller, more cost-effective pool of physicians who can demonstrate the ability to meet higher utilization management criteria.

Most PHO representatives agreed that, even if they had wanted to begin with a more selective panel, it would have been very difficult to do so, because of the political sensitivities involved and because of the lack of reliable data on individual physician practice patterns.

Role of medical management

All of the PHOs in this study either had or were in the process of implementing a medical management program to assure appropriate levels of care and the provision of high-quality, cost-effective services in both inpatient and outpatient settings. Most of the PHOs had implemented a broad range of utilization management protocols to evaluate medical necessity, including prospective, concurrent and retrospective review and case management.

All of the PHOs were exploring ways to provide better incentives for primary care physicians to manage care cost effectively; approximately half of the PHOs used a primary care gatekeeper approach.

Although most of the PHOs currently do not have the infor-

mation systems capability to compile and analyze their own utilization data, they are actively involved in acquiring, compiling and analyzing utilization data pertaining to each of their physicians. Typically this involves reviewing utilization data provided by the hospital and by insurance companies (so-called "report cards"), identifying physician outliers and undertaking educational efforts to make medically appropriate modifications in physician practice patterns.

Another significant PHO medical management initiative involves the development and implementation of practice parameters, clinical pathways and, in a few cases, drug formularies.

Regardless of a PHO's specific medical management initiatives, a common theme that surfaced throughout the discussions with PHO representatives was the importance of, and key role played by, the PHO medical director. It was emphasized frequently that this critical position must be filled by a respected, knowledgeable physician who can work effectively with both physicians and the hospital administration.

Conclusion

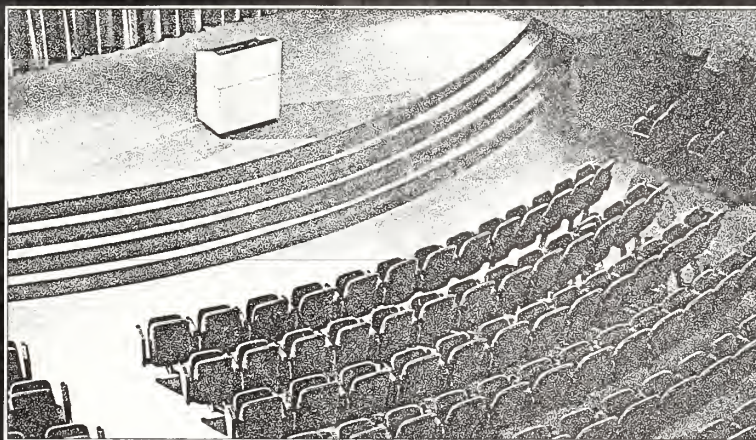
Can PHOs provide an organizational mechanism to meet the needs of patients, physicians, hospitals, business and payers? If the PHO is properly organized, capitalized, governed and administered, it can be effective in a variety of markets, including competitive managed care settings. A PHO will not be effective, however, unless it is based on a keen

understanding of the local market and is responsive to the needs of payers. Developing a sound managed care strategy, based on an in-depth market analysis, is critical to the success of a PHO.

The PHO model, however, is only one possible alternative that warrants consideration by physicians. Depending on a physician's specialty, age, goals, preferred practice style, financial resources, level of risk-tolerance and geographic location, other models may be more or less attractive – and may be more or less effective in achieving that physician's goals – than the PHO. In short, determining the right strategy for an individual physician requires a careful assessment of the above factors, in light of that physician's current situation and long-range goals. If the PHO approach is pursued, careful attention to the lessons learned from other PHOs, including those in this study, will enhance the potential for that strategy to be successful. □

Thomas M. Gorey, J.D., president of Policy Planning Associates in Crystal Lake, Ill., was a consultant on the study.

Copies of the study are available to physicians who are considering initiating or participating in a PHO. The study is \$20 for ISMA members and \$95 for non-members. To order, send your name, address, phone number and a check, payable to the ISMA, to: ISMA, attn: Toni Settle, 322 Canal Walk, Indianapolis, IN 46202-3252.



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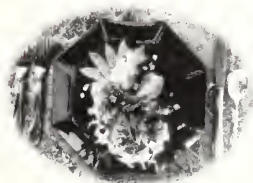
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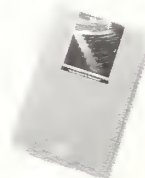
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Institutional ethics committees in Indiana:

Organization, structure and function

Margaret H. Applegate, R.N.,
Ed.D.
Ryan Finkenbine, M.D.
Gregory Gramelspacher, M.D.

In an environment influenced by rapid advances in science and medicine, the number of institutional ethics committees (IECs) in the United States is growing steadily. Early ethics committees tended to have a single focus, such as the sterilization decisions in the 1920s or abortion review in the 1950s and 1960s.¹ Institutional review boards developed rapidly in the 1960s and 1970s in response to the federal mandate to protect human subjects in research. The ruling of the New Jersey Supreme Court in the Quinlan decision influenced the contemporary growth of ethics committees. By 1988, approximately 60% of hospitals and a few extended care facilities in this country had established IECs.^{2,3}

Institutional ethics committees educate staff and community members, develop policies and guidelines and perform case reviews. Little controversy exists in the roles of education and policy formulation. However, the role of ethics committees in case review remains controversial, and little formal evaluation data exist to clarify this role.

Little is known about IECs in Indiana. The purpose of this study was to determine the organization, structure and function of institutional ethics committees in hospitals and extended care facilities (ECFs) in Indiana.

Methodology

After approval was obtained from the Institutional Review Board, a letter was sent to all hospitals (n=153) and extended care facilities (n=573) in Indiana to identify those that had IECs and to seek permission to send questionnaires to the chairpersons of these committees. The Indiana State Board of Health provided a list of facilities in the state. A follow-up letter was sent to non-respondents three weeks after the initial inquiry to complete Part I of the study.

In Part II of the study, we sent a precoded, self-administered questionnaire to the chairperson of each IEC identified in Part I (n=108). Two reminders were sent to nonrespondents at three-week intervals. Each mailing included a self-addressed, stamped return envelope.

The questionnaires, developed by the investigators, included items relating to the organization, structure and functions of the IECs. Both open-ended and fixed-alternative items were included. Experts from the Center for Clinical Medical Ethics at the University of Chicago and the Center for Survey Research at Indiana University reviewed the instrument for content validity, wording and format. The tool was revised accordingly and pretested.

Chi square was used to test for significant differences between the responses of hospitals and extended care facilities ($\alpha=p<.01$). Data were pooled without identifying information to ensure confidentiality. Consent to

participate was assumed by return of the questionnaire.

Results

Prevalence – Ninety-seven percent (n=149) of the hospitals contacted in Part I of the study responded, versus 56% (n=323) of ECFs. Forty percent (n=60) of hospitals responding to the inquiry letter reported having an IEC, versus 15% (n=48) of the ECFs ($p<.00001$). In Part II of the study, 82% (n=49) of the hospitals and 67% (n=32) of the ECFs returned the questionnaires. Table 1 demonstrates the size of institutions that responded in Part II.

Figure 1 reflects the duration of ethics committees in the sample. Significantly more hospitals than ECFs had IECs that had been in existence for more than three years ($p<.01$).

Organization and structure – Hospital ethics committees were slightly larger than those in ECFs, with the mean number of members on hospital IECs being 15.7, versus 13 for ECFs. All committees had an interdisciplinary membership though there were differences in composition. Figure 2 depicts the membership of the committees separately for hospitals and ECFs in mean percents. Hospitals tended to have more physicians, nurses and clergy on their committees, while nursing home committees had more community representatives, physicians and nurses. The number of physician and nurse members was significantly greater on hospital committees ($p<.01$) than on ECF committees while the number of com-

munity representatives was significantly greater on ECF committees ($p<.01$). Hospital committees were somewhat more likely to include an attorney or member of the clergy while ECFs were somewhat more likely to include administrators and social workers.

Figure 3 illustrates the field of practice by those designated as chairpersons of IECs. In comparison, ECFs had significantly more administrators than physicians as chairperson ($p<.003$), and hospitals had significantly more physicians than administrators in that role ($p<.01$).

Most IECs in the study report to the CEO of the institution (42%) and/or to its governing board (41%). Twenty-two percent of IECs report to an executive committee or corporate office. Finally, 20% of hospital IECs report to the chief of the medical staff, while 13% of ECF committees report to the director of quality assurance.

Although a number of respondents did not answer this question, the scheduling of committee meetings appeared to vary widely. Meeting frequency for hospitals and ECFs seem to be increasing; more committees reported at least one regular or ad hoc meeting at hospitals ($n=23$) and ECFs ($n=8$) in 1990 for respective increases of 10% and 6% during 1989. The number of regularly scheduled meetings per year ranged from one to 12 for hospitals and ECFs during 1989 and 1990. More hospitals than ECFs reported additional ad hoc meetings in both 1989 and 1990. While activity appears to be increasing, the number of committees that had never met was still high (32%).

Educational function – Fifty-

Table 1 Size of organizations which responded to the survey.

	Hospitals		ECF (N=32)	
	N	(%)	N	(%)
Licensed beds	N=49		N=32	
1 - 100	5	(10)	17	(53)
101 - 200	15	(31)	10	(31)
201 - 300	9	(18)	2	(6)
> 300	20	(41)	3	(9)

Figure 1 Existence of Committees in Years

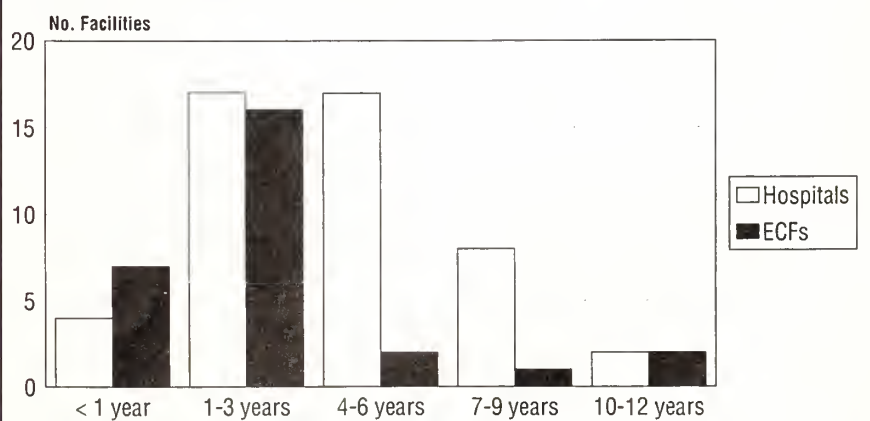


Figure 1

nine percent ($n=29$) of responding hospitals had offered at least one educational program in the last year, while only 23% ($n=7$) of ECFs reported educational activity. Twelve percent of hospitals and 6% of ECFs had sponsored four or more educational activities in the last year. Twenty-two per-

cent ($n=11$) of hospitals had budgets for educational efforts versus 6% ($n=2$) of ECFs.

Policy development – Fifty-nine percent of hospital committees and 44% of ECF committees were involved in the development of policies. Hospital IECs most often developed policies concerned with

advance directives (76%), resuscitation (74%), withdrawal of mechanical ventilators (41%) and brain death (35%). ECF committees were involved in the development of policies regarding resuscitation (69%), advance directives (69%), withdrawal of medically provided food/fluids (34%) and HIV testing of patients and/or health care providers (19%).

Case review/consultation – Most hospital committees (77%) and ECF committees (70%) conducted case reviews. Forty-nine percent of the hospital committees and 47% of the ECF committees reported an increased number of case reviews now compared to when they were first established. Most hospitals (90%) and ECFs (83%) indicated that the recommendations resulting from these reviews were advisory only, although 17% of ECFs indicated that their recommendations were binding.

Table 2 identifies the five most common types of cases reviewed by hospital and ECF committees in 1989 and 1990. Twenty-two percent of hospital committees and 28% of ECFs reported that they had done no case reviews in 1989. In 1990, 16% of hospitals and ECFs had done no case reviews.

Patients, patient representatives and professional staff could request case reviews, but in fact most requests were made by the professional staff. Hospitals reported that most case reviews had been requested by physicians (67%), followed by nurses (37%) and the families of patients (29%). In ECFs, most requests were made by social workers (38%), followed by administrators (34%) and nurses (28%). Less than half of

reporting hospitals (43%) and only a quarter of ECFs had written procedures for case reviews.

Both hospitals and ECFs conducted prospective and retrospective reviews. Hospitals did more prospective (57%) than retrospective reviews. With regard to recording recommendations on the medical record, 25% of hospitals always did so, and 28% of them never did. Nineteen percent of ECFs always recorded their recommendations, while 44% reported they never did. Others indicated that they sometimes recorded their recommendations in the medical record.

Few hospitals (6%) or ECFs (9%) consistently required patient or family consent for case review. Some hospitals (16%) and ECFs (16%) "usually" required consent, but a significant number of hospitals (23%) and ECFs (19%) never did so.

Only 8% of hospitals and 7% of ECFs in this sample reported having an ethics consultant available to consult at the bedside. Finally, participants in this study were asked whether a formal

mechanism existed to evaluate committee activity. Thirty-seven percent of ECFs had mechanisms in place for evaluation compared to 16% of the hospitals.

Discussion

Data from this study show that 40% of the hospitals in Indiana have ethics committees compared to approximately 60% of hospitals in the United States. The low response rate of ECFs to our initial inquiry (56%) limits our ability to generalize the data to all of Indiana.

Given this response rate, it is possible that ECFs without an ethics committee simply did not respond to Part I of the study. Further, those facilities that did respond may represent a biased sample. This suggests that the 15% reported prevalence rate of committees among ECFs may be greater than actually exists statewide. Related studies have reported that 2% to 10% of ECFs had active ethics committees in 1987-88.^{3,4}

Though there is anecdotal evidence that IECs are growing in

Figure 2 Committee Membership (Means)

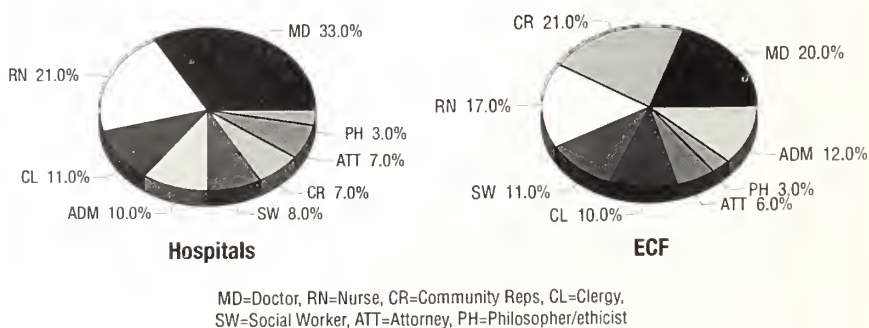


Figure 2

number, few studies exist that reflect the rate of growth. Our study indicates that the number of IECs in Indiana is growing and that the current rate of growth is greater in ECFs than in hospitals. This may be explained by the fact that few ECFs in Indiana had an ethics committee five years ago.

Our study demonstrates that IECs in Indiana are interdisciplinary in composition. Physicians and nurses predominate IEC membership in both categories of institution, but ECFs were more likely to include community representatives as members. A multidisciplinary composition provides the potential, though not assurance, of a pluralistic analysis of ethical issues. To have a philosopher, ethicist or member of the clergy with analytic skills may facilitate this effort.

Organizationally the committee should exist within the institutional structure and report ultimately to the board of trustees.⁶ Most IECs in our study were organized as standing committees responsible to administration through a chain of command.

The American Hospital Association guidelines for hospital ethics committees on biomedical ethics state that "ethics committees should not serve as professional review boards, as substitutes for legal or judicial review, or as 'decision makers' in biomedical ethical dilemmas. An ethics committee should not replace the traditional loci of decision making on these issues."⁷ Our results indicate that committees in Indiana tend to follow these guidelines, as shown by their role in education, policy development and case review.

Educational functions – Hospi-

Table 2 Most common types of cases reviewed by IECs in hospitals and extended care facilities in Indiana in 1989 and 1990.

Hospitals (N=49)			ECFs (N=32)		
Type case	N	(%)	Type case	N	(%)
Withhold/withdraw ventilator	25	(51)	Do not resuscitate	10	(31)
Withhold/withdraw nutrition/hydration	21	(43)	Withhold/withdraw nutrition/hydration	8	(25)
Do not resuscitate	19		Legal issues	8	(25)
Resolution of disagreements	20	(41)	Competency	6	(19)
Legal issues	13	(27)	Cost/rationing	6	(19)

Figure 3 Committee Chairperson

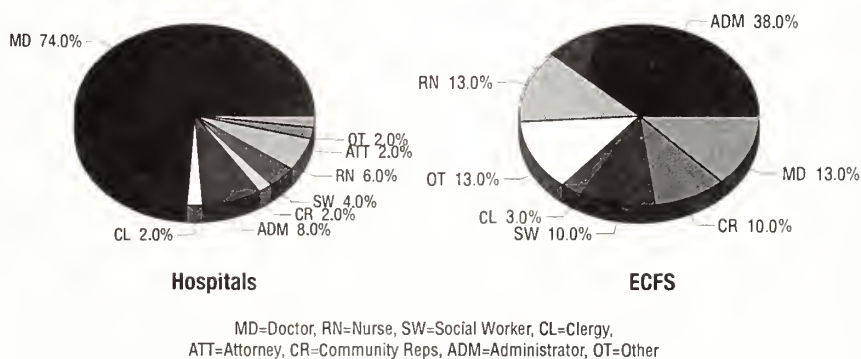


Figure 3

tal committees in this study appeared to be more involved in education than were ECF committees. The poor response rate by ECFs to this question limits interpretation. The fact that 72% of ECF committees had been in existence for only three years or less and a lack of budgetary support also may have influenced their limited involvement in education.

Most IECs provide educa-

tional opportunities to their own members. This is important because many members of newly formed IECs are attracted to membership more by interest than expertise.⁸ The foremost objective of an IEC should be the education of its own members in preparation for policy development and case review.^{9,10} Other efforts may include programs to increase the institutional health professionals'

awareness of and knowledge about bioethical issues and conflicts of common concern. Those IECs with fiscal support or access to funding often reach beyond the institution to provide educational programs to the broader community.

Policy development – Most IECs review or develop policies concerning end-of-life issues. Committees also consider such issues as informed consent, cost containment, abortion, discharge criteria for intensive care units, admission policies for the uninsured, transplantation and issues surrounding AIDS.¹¹ Most hospitals and 44% of ECFs in our sample were involved in policy formulation with a concentration on end-of-life issues and HIV testing.

The development of institutional policy is an important role for ethics committees. Each case study and ethical dilemma adds to the pool of information from which more global generalizations and, ultimately, clear policy may be drawn. Several institutions in several states have begun to “network” their IEC experiences to increase their knowledge base, allowing each facility to provide better services to employees, patients and the community through established institutional policy.¹²

Case reviews – The goal of case review is to facilitate ethical reflection and decision making by attending health care providers rather than to impose decisions.¹³ Case review may assist in decision-making, case management and conflict resolution. The ultimate goal is to improve patient

outcomes.

Case consultation is the most controversial of the traditional IEC functions. Variable membership standards and questionable legal liability have hindered their use.¹⁴ Some IECs may be too large to easily facilitate case review. Some believe that IECs interfere with clinical judgments and the physician-patient relationship.¹⁵ In the absence of evaluation data, it is difficult to respond clearly to either the advocates or critics of institutional ethics committees.

Health care facilities may conduct both mandatory and optional reviews, but in most cases, the decisions are advisory rather than binding.¹⁶ Most IECs in our study conducted advisory reviews even when mandatory review policies existed. The fact that 17% of ECF

Case consultation is the most controversial of the traditional functions.

committee decisions were binding was somewhat surprising given that this clearly is not the norm. The high percentage of binding decisions in ECFs may reflect the fact that more committees were chaired by administrators and that they dealt heavily with the development of institutional policy.

Fewer than half of the hospitals (43%) and still fewer ECFs (25%) had written procedures for case reviews. The absence of uniform procedures may decrease both the number of cases brought to the committee and the confidence of the committee in the review process. Appropriate protocols would improve communi-

cations related to notification of participants and subsequent recommendations. There were inconsistencies in these areas in the institutions surveyed.

Attending physicians and the individuals requesting reviews often were not notified of the committees' proceedings. Some committees' final recommendations were not brought to the attention of the requesting individual or the patient's attending physicians. This lack of notification is a serious flaw in procedure and precludes the participation of important parties in the discussion and implementation of recommendations. Additional studies should investigate the possible lack of communication between committees and interested parties to the conflict.

The lack of informed consent requirements by IECs in this study is another area of concern. This issue raises questions about privacy and confidentiality.

While some case reviews may not directly affect the patient and may be justified without consent, those that have implications for the patient may be controversial if consent is not obtained. While there are still questions about who should participate actively in case review, affected individuals should at least be informed of the review and be notified of committee recommendations. Confidentiality must be maintained and a patient's rights to privacy cannot be invaded blindly based on a concern of others.

The effectiveness of IECs remains to be seen. They are growing in number, and an increas-

ingly enlightened and autonomous consumer group desires and seeks support systems within or beyond health care institutions. The expanding complexity of ethical issues confronting health care practitioners demands a mechanism for formal analysis. IECs appear to provide at least one important avenue for that service. Ethics committees are crucial at this point in the history of health care especially for education, policy development and voluntary consultation.¹⁷ To be truly effective, however, institutional ethics committees must develop better evaluation processes to determine if they improve patient care. □

Dr. Applegate is a professor of nursing at the Indiana University School of Nursing in Indianapolis. Dr. Finkenbine, a graduate of the Indiana University School of Medicine, is a resident at the Medical University of South Carolina, and Dr. Gramelspacher is an assistant professor of medicine at the IU School of Medicine in Indianapolis and directs the school's program in medical ethics.

Correspondence: Margaret H. Applegate, R.N., Ed.D., Indiana University School of Nursing, 1111 Middle Drive, NU482, Indianapolis, IN 46202-5107.

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Choosing a practice management consultant

Sally Cash
Kim Howard
Evansville, Ind.

Health care management is becoming increasingly frustrating for physicians. Many find themselves faced with the task of managing a practice without the advantage of a formal education in business management. The uncertainty of health care reform now adds a new dimension to their frustration. Consequently, many physicians and group practices are looking to practice management consultants for assistance with office operations and management decisions.

Quality practice management services can certainly contribute significantly to the success of a practice. On the other hand, poor management services can lead to disastrous outcomes for the physician, office staff and their patients. The importance of choosing the right practice consultant should not be overlooked.

The selection process

The selection process should include a cautious and thorough investigation of potential consulting services. Before hiring a practice management service, the physician should determine the needs and goals of the practice. Potential management services and consultants should be evaluated

based on their ability to satisfy those goals.

Practice management consultants come from various backgrounds. Many consulting or accounting firms have developed a health care niche, but may employ consultants who have little or no clinical knowledge or experience in the day-to-day operations of a medical practice. Management consultants with medical office experience, coupled with proven management skills, may provide a more qualified alternative.

Never enter into an agreement with a consultant without checking references. A reference check of firms that offer physician management services should include inquiring about the consultants' knowledge of billing and coding procedures, OSHA and CLIA

Many consulting or accounting firms have developed a health care niche, but may employ consultants who have little or no clinical knowledge or experience in the day-to-day operations of a medical practice.

regulations, durable medical equipment billing requirements and medical background and experience.

The management of a medical practice is too important to entrust to a consultant who may look good on paper but is lacking in personal and professional skills that substantiate those qualities. A reference check should also include obtaining a list of current

and former practices managed, the exact nature of previous management engagements, the goals achieved or failed and the accuracy of time and fee estimates. The consultant's personality, communication skills and management philosophy also play a major role in determining a successful relationship.

Contract arrangements

When a consultant with the necessary qualifications has been found, a letter of proposal should be requested. The proposal should define the objectives of the engagement, a timeline for achieving the goals, who will manage the engagement and be responsible for results and an estimate of time commitments and fees.

Practice management services can be diverse by definition, and expectations must be determined before entering into a contract with a consultant. Practice management services can range from providing only billing and collection support to actual management of all areas of operation,

including personnel recruitment and training, inventory and cost controls, accounts receivable management, financial reporting and assessment, and quality assurance guidelines. A written contract that defines the objectives and scope of the arrangement is essential. The terms of the agreement should be negotiable to meet the needs of the physician and the practice. Once an agreement has

been entered into, continuous communication between the physician and consultant will enhance the success of the arrangement. Frequent monitoring of goals and progress should be provided by the consultant in the form of both verbal and written reports.

Making it work

Effective practice management is not a quick fix – it is an ongoing process that involves the physician, the staff and the consultant, working as a team toward a common goal of quality improvement. A consultant with strong leader-

ship skills can achieve this goal through teamwork and empowerment of the physician's staff. While quality improvement in health care generally focuses on patient care services, a good consultant will also strive for quality of relationships and communication.

The challenge facing physicians and consultants is how to effectively integrate the needs, goals, aspirations, values and hopes of the practice. The physician must feel confident that the management consultant chosen can fulfill these expectations.

Hiring a practice management consultant may be the inevitable solution to working through the maze of health care regulations. Finding one who possesses strong management and leadership skills and delivers quality practice management services with integrity is a challenge that requires considerable time but is an investment well worth the effort. □

The authors are practice management consultants with Associates in Management of Evansville, Ind.

Look-alike and sound-alike drug names

	FEOSOL	FLUOSOL
Category:	Iron product	Myocardial ischemia
Brand name:	Feosol, SmithKline	Fluosol, Alpha Therapeutic
Generic name:	Ferrous sulfate	Intravascular perfluorochemical emulsion
Dosage forms:	Elixir, tablets, capsules	Emulsion
	FOLIC ACID	FOLINIC ACID
Category:	Megaloblastic anemia	Antidote
Brand name:	Folvite, Lederle	Wellcovorin, BW
Generic name:	Folic acid	Leucovorin calcium
Dosage forms:	Tablets, injection	Tablets, injection, powder for oral solution

■ drug names

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

Physician serves as advocate for abused

Tina Sims
Managing Editor

Michelle Condon, M.D., is better at spotting abuse in her patients today than she was two years ago. She has learned through her own painful experience how to detect signs of domestic violence.

As a former spouse of an abusive person, Dr. Condon now serves as an advocate for battered women. In her role as an emergency physician in West Michigan, she offers to intervene on her patient's behalf, calling the police when they fail to arrest an abusive partner or volunteering to testify in court about the injuries resulting from abuse. She also speaks publicly on the topic, as she will during a panel discussion on family violence during the 1994 ISMA convention. (See story on page 383.)

"Most women are not in a position to advocate for themselves, especially after they've been abused," explains Dr. Condon.

She stayed in an abusive marriage for 12 years. Her husband seldom displayed warmth or affection, didn't value her contributions to the marriage and often threatened her with physical violence.

Such emotional abuse, she says, is a form of mistreatment that the public often does not consider domestic violence. Dr. Condon points out, however, that emotional abuse is as effective as physical violence in satisfying the abuser's need to control another person.

"We often are looking only for black eyes," Dr. Condon says. Instead, perhaps more time should be spent watching for symptoms of emotional abuse, she says, since it can be as harmful as physical violence and can predate physical violence by days, months or even years.

When her husband finally physically injured her, she didn't go to the hospital for care. "I didn't want to be one of *those people* who went to the emergency room at 2 a.m.," she explains. "Somehow I thought I was differ-

ent, more in charge of my life than patients I had treated for this problem."

Despite her experiences, Dr. Condon still refuses to think of herself as a victim. "The word 'victim' sounds like someone who is passive," she says, "and I consider myself anything but passive. I suspect though that this feeling is still a reflection on my own and society's prejudice that the victim deserves what happens to her."

Today she actively crusades for the cause of domestic violence prevention and offers sources of

Domestic violence resources to be available at convention

Posters, literature and laminated cards on domestic violence services for patients will be available for physicians during the ISMA annual convention Oct. 21 to 23. The free material, courtesy of the Indiana Coalition Against Domestic Violence, the Domestic Violence Network and the Indianapolis Mayor's Commission on Family Violence, is being distributed in conjunction with a convention panel discussion on family violence that is being sponsored by the ISMA/ISMA Alliance Family Violence Task Force.

Developed by the Domestic Violence Network, the 2-inch x 3 1/2-inch laminated referral/resource cards were designed to be small enough for a woman to conceal on her body. They contain such information as phone numbers of law enforcement agencies, support groups, counseling centers and shelters for abuse victims in Marion County and surrounding counties. The card also includes safety tips. Physicians are encouraged to give the cards to patients who they know or suspect are being abused.

The Domestic Violence Network brings together members from agencies within and surrounding Marion County that are concerned with the problem of domestic violence. The network strives to ensure consistent and continuous services for victims, perpetrators and families of domestic violence, to clarify resources and functions available to the public and professionals, to increase community awareness of domestic violence issues and to act as advocates for victims and families in the judicial system. □

help, education and support to abused patients. She understands but doesn't condone the reasons why society – physicians included – have tolerated partner abuse for so long.

"A man's home is his castle." "What people do in their free time was off limits to the judgment of the rest of the world." Such beliefs continue to perpetuate the myth that what happens in the home – including abuse – is no one else's business, Dr. Condon believes.

Many people, including physicians, tend to blame the abused woman, especially if she has been drinking, says Dr. Condon. Others can't understand why the woman doesn't simply end the relationship. Women stay, Dr. Condon explains, for a variety of economic, religious and societal reasons. Society, for example, often applies pressures on the woman to save the marriage and keep the family intact at all costs,

she says. In many cases, women are simply too afraid to leave. About 40% of women killed by partners are killed after they try to leave.

Churches don't help the matter, she points out, when ministers and priests give women such advice as "Don't make him mad, and you'll be OK." In addition, many religions, including the Roman Catholic Church, strongly condemn divorce. Dr. Condon, herself a Roman Catholic, struggled with the issue before concluding divorce was the only solution to her problem.

Television contributes to the problem by promoting the idea of women as victims, Dr. Condon says. "There are not many positive women role models on prime time TV."

Fortunately, attitudes and laws are changing. Police in many cities now have more authority to arrest abusive husbands or boyfriends. Dr. Condon won-

ders why that hasn't happened sooner. "If you beat up a stranger on the street, you will be prosecuted. But if a husband beats up his wife, the police often will not even be interested in taking a report," she says.

Physicians too are becoming more aware of signs of abuse, but there is still room for improvement. "They have to believe the patient and be their patient's advocate," she says. "They have to understand the psychology of the problem."

She encourages physicians to express concern and reassure patients that the abuse is not their fault. "We have to stop blaming the victim," she says.

Ultimately, she believes there is one way to end the violence. "We have to teach our children how to respect and honor each other as unique individuals and let them know that physical violence is just not permissible – ever." □

Indiana State Medical Association

1994 Annual Convention & Exposition

Friday, Oct. 21
Saturday, Oct. 22
Sunday, Oct. 23

Westin Hotel
Indianapolis

- * House of Delegates
- * Reference Committees
- * Health System Reform and Telemedicine Program
- * Family Violence Panel
- * IMPAC Luncheon
- * Presidents' Night Dinner and Dance

Abridged schedule of convention events

Thursday, Oct. 20

2:30 – 4:30 p.m. Board of Trustees meeting
 6 – 7 p.m. Board of Trustees reception
 7 – 9 p.m. Board of Trustees dinner

Friday, Oct. 21

7 a.m. Trade show, opening breakfast
 9 a.m. – noon House of Delegates, first session
 Noon Trade show luncheon in Exhibit Hall
 1 – 6 p.m. Reference committees
 5 p.m. Trade show reception in Exhibit Hall
 7 p.m. Afterglows

Saturday, Oct. 22

7 – 10 a.m. Board of Trustees breakfast
 8 – 10 a.m. PICI risk management seminar
 10 a.m. Health Care 2000: What's Ahead in Reform & Technology
 12:15 p.m. IMPAC luncheon
 2 – 4 p.m. Family Violence: The Physicians' Response
 6 – 7 p.m. Presidents' Night reception
 7 p.m. Presidents' Night dinner
 9 p.m. Afterglows

Sunday, Oct. 23

7 a.m. Membership Task Force breakfast
 9 a.m. – noon House of Delegates, final session
 Noon – 1:30 p.m. Trustees organizational meeting □

Official call

The House of Delegates of the Indiana State Medical Association will convene at 9 a.m., EST, Friday, Oct. 21, 1994, in Grand Ballroom 5 of the Westin Hotel in Indianapolis.

The House will reconvene for its second (final) session at 9 a.m. EST, Sunday, Oct. 23, 1994, in Grand Ballroom 5.

Representation in the House for the 1994 annual meeting will be as follows:

Indianapolis – 39 delegates
 Lake County – 15 delegates
 Allen County – 12 delegates
 Vanderburgh County – 9 delegates
 St. Joseph County – 8 delegates
 Delaware-Blackford, Monroe-Owen, Tippecanoe and Vigo-

Parke-Vermillion – 5 delegates each

Bartholomew-Brown, Elkhart, Howard, LaPorte, Madison, Porter and Wayne-Union counties – 3 delegates each

Clark, Daviess-Martin, Dearborn-Ohio, Fayette-Franklin, Floyd, Fountain-Warren, Grant, Harrison-Crawford, Jasper-Newton and Jefferson-Switzerland – 2 delegates each

The remaining 53 county medical societies – 1 delegate each

Trustees -17
 Past presidents – 19
 Resident Medical Society – 1 delegate
 Student Medical Society – 4 delegates

Total voting members of the House of Delegates – 238. □

Presidents' Night events set

Join outgoing ISMA President William C. VanNess II, M.D., and incoming ISMA Alliance President Darlene Haddawi for the 1994 Presidents' Night Reception and Dinner Dance.

Featuring the Al Cobine Orchestra, the program will begin with a reception in the Grand Ballroom at the Westin Hotel from 6 p.m. to 7 p.m. The dance floor will open following dinner.

Tickets are \$50 per person. □

Program to focus on future of reform and technology

"HHealth Care 2000: What's Ahead in Reform & Technology" will be the featured program during the ISMA annual convention. Speakers will examine the latest political developments in health care and demonstrate how new technology will impact physician practices in the future.

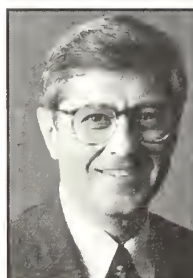
The program will begin at 10 a.m. Saturday, Oct. 22, with a key Congressional observer, John Iglehart, the national correspondent for the *New England Journal of Medicine* for the last 13 years, who will explain the status of health system reform and forecast what's ahead. Iglehart writes the regular essay, Health Policy Report, which deals extensively with the American health care system and covers the health care systems of foreign countries. He is also the

founder and editor of *Health Affairs*, a quarterly policy journal that began publication in 1981. Published by Project HOPE, it is the largest circulating

quarterly health policy journal published in the United States. Previously, at different times, he held every editorial position, including editorship, of the *National Journal*, a Washington-based privately published weekly on federal policymaking.

Telemedicine demonstration

Telemedicine and its potential for the future of health care will follow at 11 a.m. as Ben Harmon,



John Iglehart

M.D., a radiologist with Methodist Hospital in Indianapolis, demonstrates the use of fiber optics and two-way interactive video to consult with a patient undergoing diagnostic testing in another area of the hotel. Telemedicine holds the promise of providing efficient, cost effective medical care and improved access, especially in rural areas. The audience will view the procedure and be able to ask questions of participants.

John Gosbee, M.D., will discuss the educational and administrative applications of telemedicine. Dr. Gosbee is vice president for research and medical informatics at Michigan State University Kalamazoo Center for Medical Studies.

The program is provided by Ameritech. □

PICI to sponsor loss prevention seminar

Lower your liability and insurance costs by attending the 1994 Preferred Risk Loss Prevention Seminar, sponsored by Physicians Insurance Company of Indiana (PICI). The program will be from 8 a.m. to 10 a.m. Saturday, Oct. 22. PICI insureds who attend will receive a 5 percent reduction in their premium costs. "Claims free" physicians are eligible for additional credits at renewal.

Objectives of the program are:

- To illustrate a plaintiff attorney's perspective on initial contacts, case screening and causes of malpractice suits.
 - To describe transfer of care issues that impact patient care and result in malpractice claims.
 - To explain frivolous suits, countersuits and remedies, in relation to medical malpractice actions.
- Speakers will be John D.

MacDougall, M.D., PICI medical consultant; Barbara Killila, R.N., M.H.A., PICI director of education, risk management; and local plaintiff and defense attorneys.

The course has been approved for two credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association and two prescribed hours for the American Academy of Family Physicians.

The cost is \$50 in advance and \$60 at the door. □

Panel on family violence to include AMA president

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported. Between 2 and 4 million women are battered by their spouses. Physicians are frequently the first professional that a victim might turn to for assistance.

In an effort to address the problem of family violence, the ISMA/ISMA Alliance Family Violence Task Force will sponsor a panel discussion Saturday, Oct. 22, from 2 p.m. to 4 p.m. Objectives of the program, titled "Family Violence: The Physicians' Response" are to define the physician's role in detecting abuse, to discuss protocols for intervention and effective intervention techniques and to provide

available resources to assist physicians.

Participants include:

- Robert McAfee, M.D., Portland, Maine, president of the AMA and a tireless spokesman on the physician's role in alleviating family violence, who will speak on "The AMA Commitment";
- Anne Flitcraft, M.D., New Haven, Conn., a national expert on family violence, who will discuss "A Clinical Look at Domestic Violence";
- Michelle Condon, M.D.,



Dr. McAfee

Grand Rapids, Mich., an internist, emergency medicine specialist and domestic violence prevention advocate, whose topic is "Picket Fences, Ruffled Curtains, Black-Eyed Susans,"

- John Pless, M.D., an Indianapolis pathologist, who will speak on "Unmasking Child Abuse: What A Physician Should Look For"; and
- Laura Berry, executive director of the Indiana Coalition Against Domestic Violence, who will discuss victim assistance resources in Indiana.

This program has been reviewed and is acceptable for 2 prescribed hours by the Indiana Academy of Family Physicians. The Indiana Academy of Family Physicians is co-sponsoring the program. □

CNN reporter to speak at IMPAC lunch

Charles Bierbauer brings more than 25 years of journalism experience to his CNN assignment as senior



Charles Bierbauer

Washington correspondent. In his address to the annual IMPAC luncheon at noon Saturday, Oct. 22, Bierbauer will share his knowledge of the way Washing-

ton works.

Since 1985, Bierbauer has been moderator of "Newsmaker Saturday," a weekly report featuring in-depth interviews with leading newsmakers. He served as CNN's senior White House correspondent for nine years during the Reagan and Bush administrations. A former foreign correspondent for ABC News, Bierbauer reported from Moscow and Bonn from 1978 to 1981.

The IMPAC luncheon is open to all members. Tickets are \$18. □

You could win a vacation

Physicians are encouraged to visit the trade show exhibits for a chance to win the grand prize of 900 "ATA Dollars!" Exhibitors will stamp your "passport" as you visit each booth during the one-day only trade show on Friday, Oct. 21. After your passport is fully validated by every exhibitor, you may deposit it in the suitcase located on the trade show floor to await the drawing.

The winner of a \$900 American Trans Air trip to an ATA destination of the winner's choice will be drawn at 6:30 p.m. during the Friday trade show reception. □

ISMA Alliance to hold annual convention

The ISMA Alliance will hold its 50th annual convention Oct. 20 through Oct. 22 at the Westin Hotel in conjunction with the ISMA's Annual Convention.

In addition to the events listed below, the alliance will have a hospitality room and sponsor an AMA-ERF fundraiser for the Indiana University School of Medicine.

Schedule of events

Friday, Oct. 21

11 a.m. ISMA-A House of Delegates meeting immediately following adjournment of the ISMA House of Delegates

12:30 p.m. Luncheon honoring former ISMA-A presidents
2:15 p.m. Reconvene business session
5 p.m. Social hour in ISMA Exhibit Hall
6 p.m. Dinner honoring county alliance presidents. Darlene Haddawi, incoming ISMA-A president, and ISMA president-elect William Cooper, M.D., will speak. Jimmy Ryser, Indiana recording artist, will speak and perform.

9 p.m. Reception honoring incoming Alliance President Darlene Haddawi
Line dancing

Saturday, Oct. 22

9 a.m. ISMA-A House of Delegates
Noon IMPAC Luncheon
2 p.m. Program on family violence
6 p.m. Presidents' Night Dinner and Dance

Alliance members should have received a convention brochure and a detailed registration form. For more information, call Rosanna Iler at the ISMA, 1-800-257-4762 or (317) 261-2060. □

Specialty groups schedule meetings

Two specialty groups will meet during the annual ISMA convention.

The Association of Indiana Directors of Medical Education will hold its annual meeting from noon to 2:30 p.m. Oct. 21.

The semi-annual meeting of the Indiana Roentgen Society will be held Oct. 22. The executive meeting will begin at 8 a.m., followed by the general membership meeting at 9 a.m.

For information on these meetings, call Dotty Martens at the ISMA, (317) 261-2060 or 1-800-257-4762. □

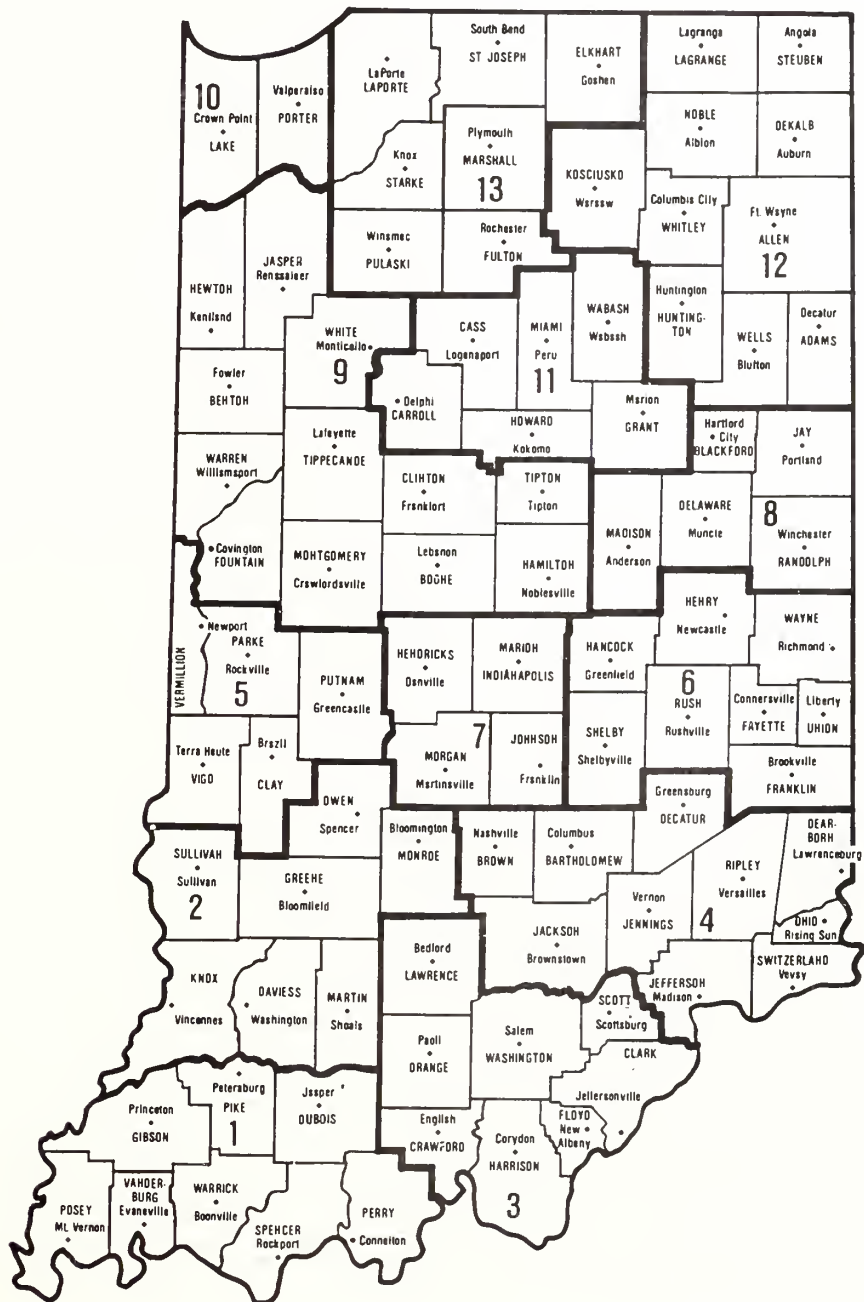
Membership task force plans breakfast

To recognize the contributions of women, minority and international physicians, the ISMA Membership Task Force will sponsor a breakfast from 7 a.m. to 8:30 a.m. Sunday, Oct. 23. The breakfast will provide an opportunity for the ISMA's women, minority and international physicians to

meet with leadership before the closing session of the House of Delegates.

There is no charge for the continental breakfast, but if you plan to attend, please indicate that on the registration form included in the convention brochure that was mailed in August. □

ISMA trustee districts





William C. VanNess II, M.D., president
Indiana State Medical Association
1993-94

Presidents of ISMA since its organization

Medical Convention

	Elected	Served
* Livingston Dunlap, Indianapolis	1849	1849

Medical Society

	Elected	Served
* William T.S. Cornett, Versailles	1849	1850
* Ashahel Clapp, New Albany	1850	1851
* George W. Mears, Indianapolis	1851	1852
* Jeremiah H. Brower, Lawrenceburg	1852	1853
* Elizur H. Deming, Lafayette	1853	1854
* Madison J. Bray, Evansville	1854	1855
* William Lomax, Marion	1855	1856
* Daniel Meeker, LaPorte	1856	1857
* Talbot Bullard, Indianapolis	1857	1858
* Nathan Johnson, Cambridge City	1858	1859
* David Hutchinson, Mooresville	1859	1860
* Benjamin S. Woodworth, Fort Wayne	1860	1861
* Theophilus Parvin, Indianapolis	1861	1862
* James F. Hibberd, Richmond	1862	1863
* John Sloan, New Albany	1863	-
* John Moffett (acting), Rushville	1863	1864
* Samuel L. Linton, Columbus	1864	-
* Wilson Lockhart (acting), Danville	1864	1865
* Myron H. Harding, Lawrenceburg	1865	1866
* Vierling Kersey, Richmond	1866	1867
* John S. Bobbs, Indianapolis	1867	1868
* Nathaniel Field, Jeffersonville	1868	1869
* George Sutton, Aurora	1869	1870
* Robert N. Todd, Indianapolis	1870	1871
* Henry P. Ayres, Fort Wayne	1871	1872
* Joel Pennington, Milton	1872	1873
* Isaac Casselberry, Evansville	1873	-
* Wilson Hobbs (acting), Knightstown	1873	1874
* Richard E. Houghton, Richmond	1874	1875
* John H. Helm, Peru	1875	1876
* Samuel S. Boyd, Dublin	1876	1877
* Luther D. Waterman, Indianapolis	1877	1878
* Louis Humphreys, South Bend	1878	-
* Benjamin Newland (acting), Bedford (v.p.)	1878	1879
* Jacob R. Weist, Richmond	1879	1880
* Thomas B. Harvey, Indianapolis	1880	1881
* Marshall Sexton, Rushville	1881	1882
* William H. Bell, Logansport	1882	1883
* Samuel E. Mumford, Princeton	1883	1884
* James H. Woodburn, Indianapolis	1884	1885
* James S. Gregg, Fort Wayne	1885	1886
* Gen. W. H. Kemper, Muncie	1886	1887
* Samuel H. Charlton, Seymour	1887	1888
* William H. Wishard, Indianapolis	1888	1889
* James D. Gatch, Lawrenceburg	1889	1890
* Gonsolvo C. Smythe, Greencastle	1890	1891
* Edwin Walker, Evansville	1891	1892
* George F. Beasley, Lafayette	1892	1893
* Charles A. Daugherty, South Bend	1893	1894
* Elijah S. Elder, Indianapolis	1894	-
* Charles S. Bond (acting), Indianapolis	1894	1895
* Miles F. Porter, Fort Wayne	1895	1896
* James H. Ford, Wabash	1896	1897
* William N. Wishard, Indianapolis	1897	1898
* John C. Sexton, Rushville	1898	1899
* Walker Schell, Terre Haute	1899	1900
* George W. McCaskey, Fort Wayne	1900	1901
* Alembert W. Brayton, Indianapolis	1901	1902
* John B. Berteling, South Bend	1902	1903
* Jonas Stewart, Anderson	1903	1904
* George T. MacCoy, Columbus	1904	1905
* George H. Grant, Richmond	1905	1906
* George J. Cook, Indianapolis	1906	1907
* David C. Peyton, Jeffersonville	1907	1908
* George D. Kahlo, French Lick	1908	1909
* Thomas C. Kennedy, Shelbyville	1909	1910
* Frederick C. Heath, Indianapolis	1910	1911
* William F. Howat, Hammond	1911	1912
* A. C. Kimberlin, Indianapolis	1912	1913
* John P. Salb, Jasper	1913	1914
* Frank B. Wynn, Indianapolis	1914	1915
* George F. Keiper, Lafayette	1915	1916
* John H. Oliver, Indianapolis	1916	1917
* Joseph Ritus Eastman, Indianapolis	1917	1918
* William H. Stemm, North Vernon	1918	1919

* Charles H. McCully, Logansport	1919	1920
* David Ross, Indianapolis	1920	1921
* William R. Davidson, Evansville	1921	1922
* Charles H. Good, Huntington	1922	1923
* Samuel E. Earp, Indianapolis	1923	1924
* Eldridge M. Shanklin, Hammond	1924	1925

Medical Association

	Elected	Served
* Charles N. Combs, Terre Haute	1925	1926
* Frank W. Cregor, Indianapolis	1926	1927
* George R. Daniels, Marion	1926	1928
* Charles E. Gillespie, Seymour	1927	1929
* Angus C. McDonald, Warsaw	1928	1930
* Alois B. Graham, Indianapolis	1929	1931
* Franklin S. Crockett, Lafayette	1930	1932
* Joseph H. Weinstein, Terre Haute	1931	1933
* Everett E. Padgett, Indianapolis	1932	1934
* Walter J. Leach, New Albany	1933	1935
* Roscoe L. Sensesch, South Bend	1934	1936
* Edmund D. Clark, Indianapolis	1935	1937
* Herman M. Baker, Evansville	1936	1938
* Edmund M. Van Buskirk, Fort Wayne	1937	1939
* Karl R. Ruddell, Indianapolis	1938	1940
* Albert M. Mitchell, Terre Haute	1939	1941
* Maynard A. Austin, Anderson	1940	1942
* Carl H. McCaskey, Indianapolis	1941	1943
* Jacob T. Oliphant, Farmersburg	1942	1944
* Nelson K. Forster, Hammond	1943	1945
* Jesse E. Ferrell, Fortville	1944	1946
* Floyd T. Romberger, Lafayette	1945	1947
* Cleon A. Nafe, Indianapolis	1946	1948
* Augustus P. Hauss, New Albany	1947	1949
* C. S. Black, Warren	1948	1950
* Alfred Ellison, South Bend	1949	1951
* J. William Wright, Indianapolis	1950	1952
* Paul D. Crimm, Evansville	1951	1953
* William Harry Howard, Hammond	1952	1954
* Walter L. Porteus, Franklin	1953	1955
* Walter U. Kennedy, New Castle	1954	1956
* Elton R. Clarke, Kokomo	1955	1957
* M. C. Topping, Terre Haute	1956	1958
* Kenneth L. Olson, South Bend	1957	1959
* Earl W. Mericle, Indianapolis	1958	1960
* Guy A. Owsley, Hartford City	1959	1961
* Harry R. Stimson, Gary	1960	1962
* Maurice E. Glock, Fort Wayne	1961	1963
* Donald E. Wood, Indianapolis	1962	1964
* Joseph M. Black, Seymour	1963	1965
* Kenneth O. Neumann, Lafayette	1964	1966
* Eugene S. Rifner, Van Buren	1965	1967
* G. O. Larson, LaPorte	1966	1968
* Patrick J. V. Corcoran, Evansville	1967	1969
* Lowell H. Steen, Hammond	1968	1970
* Malcolm O. Scamahorn, Pittsboro	1969	1971
* Peter R. Petrich, Attica	1970	1972
* James H. Gosman, Indianapolis	1971	1973
* Joe Dukes, Dugger	1972	1974
* Gilbert M. Wilhelmus, Evansville	1973	1975
* Vincent J. Santare, Munster	1974	1976
* John W. Beeler, Indianapolis	1975	1977
* Eli Goodman, Charlestown	1976	1978
* James A. Harshman, Kokomo	1977	1978
* Arvine G. Popplewell, Indianapolis	1978	1979-80
* Alvin J. Haley, Carmel	1979	1981
* Martin J. O'Neill, Valparaiso	1980	1982
* John A. Knote, Lafayette	1981	1983
* George T. Lukemeyer, Indianapolis	1982	1984
* Lawrence E. Allen, Anderson	1983	1985
* Paul Siebenmorgen, Terre Haute	1984	1986
* Shirley Thompson Khalouf, Marion	1985	1987
* John D. MacDougall, Beech Grove	1986	1988
* Fred W. Dahling, New Haven	1987	1989
* George H. Rawls, Indianapolis	1988	1990
* Michael O. Mellinger, LaGrange	1989	1991
* C. Dyke Egnatz, Schererville	1990	1992
* William H. Beeson, Indianapolis	1991	1993
* William C. VanNess II, Summitville	1992	1994

* Deceased

■ annual reports

Editor's note: The annual reports that were not submitted in time to be included in this issue will be printed in the January 1995 issue of INDIANA MEDICINE.

EXECUTIVE COMMITTEE

William C. VanNess II, M.D.
president

Health system reform continued to dominate the past year even though no one was sure what the final outcome would be. Whatever is forthcoming from the Congress combined with the market forces impacting on how medicine is practiced will have a major effect on the ISMA and its influence in the future.

The ISMA's strength is in its numbers. To increase our organization's representation base, the Executive Committee recommended to the board a staff-developed action plan for membership recruitment. The objective is to increase ISMA membership by 5% by Dec. 31, 1995, using existing staff combined with peer-to-peer physician contact. Another recruitment tool to be used is a newly designed membership brochure that features testimonials from ISMA members about member benefits.

To assist the ISMA in successfully representing its members' interests efficiently and effectively, continued improvements were made to the local area network computer system. New software is being used to collect and interpret more data on members, their practices and their needs. Survey results will be available to ISMA members in the aggregate.

The Executive Committee approved an allocation of \$5,000 to participate in Phase II of the PHO study completed earlier this year.

This joint project with the AMA, the Michigan State Medical Society and the Illinois State Medical Society will study physician organizations. As with the PHO study, a final report will be available to members. It is an appropriate role for the ISMA to assist its members by providing information on new developments in the health care delivery system.

In another fiscal matter, the Executive Committee approved an early payoff of the MU-2 aircraft purchased in May of 1993. The Executive Committee continues to monitor and evaluate the financial status of the aircraft.

On the national health system reform front, the ISMA vocally supported the Patient Protection Act and the Hatch-Archer anti-trust bill. An editorial stating the ISMA's position in favor of the Patient Protection Act appeared in several newspapers across the state, and the circulation of the editorial prompted other papers to do additional articles on the issue. We also have written our Congressional delegation to urge their support of both.

There were no new threats to the Indiana Compensation Act for Patients (INCAP) during the past year, thanks, in part, to the groundwork we have laid to educate legislators and the public. But the trial lawyers remain adamant that the law should be changed. Periodically they have authored editorial columns criticizing INCAP that have been published in various newspapers. We remain committed to protecting INCAP and have continued to include information about INCAP in our meetings with state legislators and with members of the Congress. Our goal is to make certain that the provisions of INCAP are not superseded by tort

reforms contained in a national health system reform plan.

The ISMA Executive Committee has concerned itself this year with making fiscal decisions that will better provide our members with the assistance they need to stay abreast of the changing medical practice environment. Our efforts are to position the ISMA as your advocate. We also must continue to position the ISMA as a patient advocate through participation in public forums on health system reform, media interviews on health topics, published articles and coalition development with groups that share our concern.

BOARD OF TRUSTEES

Jerome Melchior, M.D., chairman

Market forces during the past year have eclipsed the health system reform debate in the Congress to present many physicians with options they might never have anticipated nor considered before in their medical careers. The Indiana State Medical Association has taken major steps to assist physicians in finding answers to their questions about the changing health care environment, practice management and managed care.

A day-long workshop in January on managed care, physician organizations and physician hospital organizations drew more than 200 ISMA members. The program featured both national and state experts who provided a wealth of information on everything from how to build a successful integrated delivery system to evaluating a managed care contract. A second program is planned for November to help ISMA members stay abreast of new developments that continue

to have impact on how health care is delivered. This program is in addition to the regularly scheduled practice management, coding and regulatory workshops the ISMA has conducted.

The ISMA participated with the AMA and the Michigan and Illinois state medical societies in a study of physician hospital organizations (PHOs) and the physician organizations (POs) associated with them. The study did not reflect an endorsement of managed care, nor of the PHO concept, but was conducted as part of our effort to provide timely communication on significant changes in the organization, delivery and financing of health care services. The study included the role of the PO in the development and operation of PHOs, the importance of leadership by physicians, the role of the hospital board and administration, the role of primary care physicians, information systems, capitalization, management, operations, contracting and payment arrangements and credentialing, among other topics.

The study concludes that "properly organized, capitalized, governed and administered PHOs can be effective in a variety of markets." They will not be effective, however, without a "keen understanding" of the local market and responsiveness to the needs of payers. The study confirmed the importance of a PO in the formation and ongoing operation of a PHO. But further study of POs that have not elected to joint venture with a hospital through a PHO arrangement seems warranted. The ISMA is participating in a Phase II follow-up study focusing on such POs. That information will be available soon.

Changes in the Medicaid program, including reduced fees,

remained on the ISMA's list of concerns this year. The ISMA aggressively represented physicians on this issue via two parallel tracks: On the one hand, we continued negotiations with the state to change the fee schedule. At the same time, we prepared for the possibility that the state would not change the fee schedule and that a judicial remedy would be necessary. In our view, the fee reduction violates the federal requirement that Medicaid programs must reimburse physicians so that Medicaid recipients enjoy the same access as private paying patients. In other words, the change in reimbursement may lead to a lack of equal access to medical services for Medicaid recipients.

The ISMA is not a group that takes lawsuits lightly. As this is being written, every effort is being made to exhaust negotiations with the governor's office before filing a suit.

There were no health system reform proposals heard in the Indiana General Assembly this last session. Indiana legislators, like those in many other states, waited for Congressional proposals expected to be forthcoming this fall. In spite of that, the ISMA has positioned itself for a leadership role in state health system reform efforts. ISMA past president Michael Mellinger, M.D., was appointed to serve on an advisory group to the governor's special assistant for health care. Legislators received "A Proposal for Health System Reform," the ISMA plan, which was adopted by the 1993 ISMA House of Delegates. Representatives of the ISMA staff have formed a working group with representatives of the Indiana State Chamber of Commerce, the Indiana Manufacturers Association

and the Indiana Hospital Association to prepare consensus health system reform draft legislation.

On another front, the department of government relations staff met over the summer with Congressional representatives and state legislators to talk about a wide range of issues, not just health system reform. Members of the ISMA and several specialty societies turned out in force for a July town meeting scheduled by Sen. Dan Coats at Butler University in Indianapolis. Members of the ISMA Board of Trustees have authored letters to the editor of their local newspapers, spoken to civic and community organizations and participated in media interviews and panel discussions on the issue of health system reform. This is in addition to the ISMA's speakers bureau participants who have completed 67 speaking engagements in the past year.

One key point that we have tried to get across to our audiences is that the natural advocates for patients are physicians, not alliances, insurance companies, lawyers or politicians. Over the long term, the interests of physicians and the public are identical: better health for all.

AMA DELEGATION

Marvin E. Priddy, M.D., chairman

I would like to thank the members of our delegation for their dedication and effort in maintaining Indiana's active role at the AMA House of Delegate meetings:

Delegates

John Knotte, M.D., Lafayette
Mike Mellinger, M.D., LaGrange
George Lukemeyer, M.D.,
Indianapolis

■ annual reports

John MacDougall, M.D.,
Indianapolis
Shirley Khalouf, M.D., Marion

Alternate Delegates

Alfred Cox, M.D., South Bend
Max Hoffman, M.D., Covington
William Beeson, M.D.,
Indianapolis
George Rawls, M.D., Indianapolis
Barney Maynard, M.D., Evansville

Interim meeting

The AMA House of Delegates met Dec. 5-8, 1993, in New Orleans with 435 delegates representing state medical associations, national medical specialty societies, special sections and government services.

The delegates considered 101 reports and 193 resolutions. Broad issues of health system reform were discussed, including mandated employer health care benefits, universal coverage and access to health care services, individual health insurance, the health IRA, cost containment, the definition of "primary care," managed care and managed competition.

At the direction of the ISMA House of Delegates, the Indiana delegation introduced eight resolutions: 1, 104, 105, 107, 211, 702, 807, 818. Resolution 1 dealing with restrictive covenants/AMA ethics was not adopted by the AMA House of Delegates. Resolutions 104 and 105 concerning employer mandated health insurance and health care savings accounts were considered jointly with several other resolutions, and the House adopted the recommendations contained in Board of Trustees Report 41 - Individual Health Insurance in lieu of the resolutions.

Resolution 107 - Opposition to a National Health Board was amended and the House adopted

the following substitute resolution: "Resolved, That policy 165.945(1)(d) be amended to read 'The AMA supports the creation of a national health advisory body or task force that will form a public/private partnership including the AMA to recommend health policy.'"

Resolution 211 - United States Surgeon General was amended as follows:

"Resolved, That in order to best protect the health care needs of the American people, the American Medical Association seek changes in federal law to require that the Surgeon General of the United States be a physician (doctor of medicine/doctor of osteopathy) whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis."

Resolution 702 - Standardization of Managed Care Office Safety Standards was amended and the House adopted the following substitute resolution:

"Resolved, That the American Medical Association oppose duplicative efforts by managed care organizations to develop physician office safety standards that have already been implemented by federal and/or state regulations; and be it further

"Resolved, That the AMA urge the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, the Accreditation Association for Ambulatory Health Care and other relevant accreditation organizations to seek greater simplification and standardization of such office review efforts as a means of reducing health care costs and unnecessary burdensome paperwork for physicians and their employees."

Resolution 807 - Hospital Staff

Consultation in Suspected Terminal Cases was considered, and the House reaffirmed Policy 140.995 - Hospital Ethics Committee - in lieu of the resolution. Resolution 818 - Regulation of Electronic Signature Process - was referred to the Board of Trustees for decision.

Annual meeting

The 1994 Annual Meeting, held June 12-16 in Chicago, included 430 voting delegates and 106 reports and 212 resolutions for consideration.

The most common topic of conversation and discussion was the increasing number of conflicts in medicine. Passage of the Patient Protection Act is of paramount importance. This act requires that all patients be completely informed concerning their health insurance (i.e., what it covers, any components, the limitations in choice of physicians, stability of the company and degree of portability). Likewise, the act protects the physician in the same manner as our any willing provider law.

The AMA House refused to accept the Council on Ethics and Judicial Affairs recommendation that physicians ethically could not: 1) use samples for their own family use; 2) treat their own families; and 3) accept appropriate gifts from industry.

We vigorously opposed and even condemned patenting of medical and surgical procedures as is happening at a surprisingly increasing rate. We are appealing to Congress to outlaw these practices, as improvements in medicine could be curtailed.

The House recommended that the Board of Trustees continue to implement AMA policy to achieve universal access and coverage of all Americans through an ap-

proach that may utilize employers and/or individual responsibilities and that permits the individual to choose and own his or her own health insurance plan. The House continues to encourage health IRAs and a phase-in mechanism and is exploring all concepts that accomplish access to and coverage for all Americans while recognizing the differing needs of the states.

The students and residents, assisted by many members of the House, opposed: 1) government allocations of residency positions (50% primary care and only 50% subspecialty; 2) limiting residency positions to 110% of the graduating students; and 3) continued funding of only primary care residencies. The students and residents also wanted patients to have direct access to subspecialists.

The Indiana delegation again took a position of strong opposition to the National Health Board.

We urged assistance to the handicapped onto aircraft with fewer than 30 seats. Currently, such assistance is not required.

The AMA House wants to replace the present CLIA with one based on the actual cost of the test. Inexpensive tests need not be under CLIA. Only complex expensive tests should come under CLIA's jurisdiction.

The House took a strong stand that physicians be allowed to contract privately with their patients. We also want the right to negotiate with the insurance companies.

An attempt to repeal the National Childhood Vaccine Injury Compensation Program was not passed. The delegates agreed to support to continue the programs working with the U.S. Public Health Service and American Academy of Pediatrics to ensure

the program maintains a scientific and rational basis for just compensation.

The AMA will continue its vigorous efforts against violence and abuse in the workplace, the hospital, the home and media.

Requiring doctors to write more legibly was one way presented to prevent medication errors in the hospital. National media highly publicized the content of this report.

Disclosure of prices and pricing methods by drug manufacturers produced considerable debate. We decided to rely on the wisdom of the Board as to whether or not such disclosures would be beneficial.

The House requested support by the AMA legal staff, if requested, to hospital medical staffs when the hospital board unilaterally amended, changed or substituted the hospital constitution or bylaws against the will of the medical staff or where seats on the hospital board are denied to duly elected medical staff officers.

The House elected Lonnie Bristow, M.D., president-elect; Daniel Johnson Jr., M.D., speaker of the house; and Richard Corlin, M.D., vice speaker. Shirley Khalouf, M.D., Marion, was elected by the House to her first term on the AMA Council on Constitution and Bylaws. John Knot, M.D., Lafayette, and George Lukemeyer, M.D., Indianapolis, continue to represent Indiana on the AMA Council on Medical Service and the AMA Council on Medical Education, respectively.

The entire delegation works diligently at each AMA meeting to voice the "Indiana perspective" on vital issues affecting the Hoosier physician and the delivery of health care in the state. If you

can't attend the meetings, you can still be assured that you are represented through your delegation. Let us know your opinions!

TREASURER

Timothy N. Brown, M.D.,
treasurer

An unaudited report of the revenues, expenditures and balance sheet of the ISMA as of Aug. 31, 1994, is available during the sessions of the House of Delegates and is referred to Reference Committee 1.

The ISMA has reached 82% of its strategic plan goal to have 18 months of operations reserve in cash and cash equivalents. As of May 31, 1994, 15 months of operations are in cash and cash equivalents.

RESIDENT MEDICAL SOCIETY

Ruchir Sehra, M.D., trustee

The ISMA Resident Medical Society (RMS) continues to be active regarding state and national issues. Membership recruiting statewide and national workforce planning were two issues of concern this year.

At the state level, the RMS enhanced its membership recruiting efforts since the 1993 ISMA annual convention. The ISMA approved a proposal, starting with the July 1994 internship class, which allows incoming residents to pay a one-time fee for three years of membership. This decreased financial burden should encourage more resident physicians to become members.

New residents will receive ISMA membership benefits from July to January before the start of the regular ISMA membership

■ annual reports

year in January. Increasing membership in the RMS may increase future ISMA membership and may result in additional Indiana delegates to the AMA annual and interim meetings.

Nationally, the ISMA RMS continues to be active in the AMA Resident Physicians Section (RPS), sending full delegations to the AMA 1993 interim meeting and the 1994 annual meeting. The major issue facing residents is workforce planning. The AMA RPS, after lively debate at the 1994 AMA annual meeting, opposes any quota system in determining physician specialty distribution. This policy does not affect proposals that encourage medical students and residents to choose certain specialties or geographical locations using varied incentives.

Deborah Stoner, M.D., an ISMA RMS delegate, was the recipient of the Burroughs Wellcome Award for her involvement in local health care efforts.

The ISMA RMS thanks the ISMA, particularly the board of trustees, for its continued support of RMS activities. We look forward to a more active year with increased resident membership.

PHYSICIANS INSURANCE COMPANY OF INDIANA

M. Dave Duncan, PICI president and CEO

1993 was a very successful year for PICI and provided substantial momentum as we entered 1994, our 12th year of serving Indiana physicians, their corporate entities, medical staffs and health care colleagues.

Our policyholder base continues to increase. The flexibility of the MedGroup program, designed for medical groups and corpora-

tions with four or more physicians, attracts single- and multi-specialty groups of all sizes. The Preferred Risk Program, which provides premium credits for participation in a PICI risk management seminar and for claims-free experience, motivates solo practitioners and smaller groups (less than four) to choose PICI.

PICI continues to demonstrate a strong commitment to aggressive, skilled claims and legal defense services. Frivolous and unwarranted claims are opposed vigorously. Our requirement for the policyholder's claim record is accurate and does not include a claim settled for "nuisance value." PICI's legal defense attorneys operate as a team and are recognized statewide for outstanding knowledge and expertise in defendant professional liability services.

PICI also continues to emphasize the importance of an insurer's fiscal strength and stability. The medical professional liability insurance industry nationally has been adversely impacted by the failure of several insurers during the past two years. At least two of the failed companies had solicited business in Indiana. Fortunately, the total number of Indiana physicians affected is modest. Nonetheless, the problems of those insurers and their policyholders prove once again the necessity and wisdom of following sound fiscal policies and philosophies. That's why PICI's rate levels are appropriate for the risk exposure involved, loss reserves are adequate for reported and not-yet reported claims, investment policies are conservative, and tight controls are maintained on operating expenses.

The successful results of these operating commitments are indicated by 1993's audited

financial statements, which are provided to Indiana physicians and other interested parties. PICI may be of modest size in comparison with some multi-state insurers who offer coverage in Indiana, but we are pleased and proud to fully disclose our operating results and financial position.

Increasingly, PICI is the preferred source of protection for Indiana's osteopathic physicians, dentists, podiatrists and other health care professionals. We have developed broad-based coverage programs for health care networks and health services entities. By serving institutional as well as individual professional liability protection needs, we are adapting and responding to the rapidly changing health care environment.

The characteristics of the health care arena today make our relationships with Indiana physicians and the ISMA ever more important. The form and scope of federal health care reform remain largely undetermined at this time. But it is likely that the political solution to the widely diverse possible courses of action will be a "phased-in reform" over an extended period of time. Many major and controversial reform measures may be delayed for future consideration and implementation.

Meanwhile, the health care industry is accomplishing self-reform in response to pressures from employer and consumer groups. The probability of a changing health care system for the future underscores the singular most important aspect of PICI's strategic planning process. This preparation must include the ability and willingness to show flexibility in responding to opportunities that will assure the ongoing achievement of our founding

objectives and purpose.

PICI's 12-year record of success has been necessitated and made possible by its dedication to serving Indiana physicians. Physicians always have been and always will be the central core of the health care delivery system. We are fully aware that leadership in serving Indiana physicians is our most important, meaningful and lasting strength and must be the driving force in every aspect and facet of our activities.

FIRST DISTRICT

Barney Maynard, M.D., trustee

I am happy to report that the First District continues its active support for organized medicine in general and the ISMA in particular. There have been continued interest in health system reform and attempts to get physicians' viewpoints heard.

The officers of Vanderburgh County spoke to eight local civic groups concerning health system reform. Several meetings were held between local physicians and state legislators. Representatives of Vanderburgh County met twice with Rep. Frank McCloskey last spring to voice concerns on many issues.

All members of the First District continue to watch legislative activity at the state and federal levels quite closely. Many of our physicians participated in the ISMA legislative alerts during the state legislative session, particularly regarding preservation of the "any willing provider" provisions to PPO statutes and insertion of language regarding artificial hydration and nutrition in living wills. Compliments go to the First District Medical Alliance, which has been especially active in this

area.

Special recognition must be given to the physicians of Dubois County. Responding to a call for the support of Timothy Brown, M.D., in his election bid, the Dubois County physicians raised a large sum of money for Dr. Brown's campaign. These physicians have demonstrated the farsighted thinking that is necessary if physicians are to have a voice in policymaking. All physicians in Indiana owe a large "thank you" to this small county, which so generously supported a non-local candidate and helped make possible the presence of a physician in the Indiana House of Representatives at this critical juncture in the evolution of health system reform.

Two special Vanderburgh County programs should be mentioned. After a four-year absence, the mini-internship will return in the fall. The expected intern class will include three members of the Indiana House of Representatives and one member of the Indiana Senate. Two local health care reporters also are expected to participate. This program will be a chance for some of our local policymakers and commentators to learn what physicians do and how difficult it is to practice today.

Vanderburgh County also will continue a managed care contract review program. This program involves the review of any managed care contract by a local attorney with special interest in this area of law if at least 25 physicians ask for the review. This service has served our physicians well, has helped educate doctors about the pitfalls of managed care contracting and has resulted in more equitable contracting.

The First District annual

meeting was held May 19. Bruce Pearl, coach of the University of Southern Indiana basketball team, spoke. William VanNess II, M.D., ISMA president; William Cooper, M.D., ISMA president-elect; and Jerome Melchior, M.D., ISMA chairman of the board, also attended the meeting.

The First District will continue to support the efforts of the ISMA. Physicians and their spouses will continue to stay abreast of the rapidly changing world of health care and, through continued legislative contacts, hope to protect the physician/patient relationship.

SECOND DISTRICT

Jerome Melchior, M.D., trustee

It has been a pleasure to serve you as trustee for the second district during 1994. I have detailed many of the organization's accomplishments in the chairman of the board of trustees report, which is printed above.

The Second District had its annual meeting in May. It was well-attended, and Ralph Stewart, M.D., reported on the "Mysteries of the Medical Licensing Board."

I wish to directly thank all of the physicians in our district who have responded to the many calls for action on specific legislative problems this year. It is you, the grassroots physicians, calling your legislators, who have the best chance of educating them. Your involvement is mandatory since it is the legislators who regulate, in many instances, the type and quality of care your patients may receive.

As your trustee, I specifically wish to thank the ISMA staff and especially our field staff representative, Janna Kosinski. Their valuable assistance allows us to be

■ annual reports

active at the state level while maintaining full-time practices.

FOURTH DISTRICT

Arthur C. Jay, M.D., trustee

The Fourth District quarterly meetings were well attended by members. Discussions centered around items of vital interest, including health reform issues and the ongoing controversy with Medicaid, especially the provider tax. There was discussion concerning the shortage of physicians in some areas and how to recruit physicians effectively. Other topics discussed were managed care and how to participate in that and/or compete against the large managed care HMOs.

The Fourth District expressed its support of William Cooper, M.D., ISMA president-elect. The district president is Alan Kohlhaas, M.D., and the secretary is Gerald Bowen, M.D., both of Lawrenceburg. Fourth District president-elect is Leon Michl, M.D., of Madison.

The annual meeting was held at the Greensburg Country Club and was attended by 26 district members. Forty-seven attendees, including officers and spouses, made the meeting an active event with good discussions. George Lukemeyer, M.D., gave an excellent talk on the trends in medical school admissions.

We sincerely appreciate the help of and information from ISMA Executive Director Rick King and Janna Kosinski, ISMA field representative. We look forward to next year and hope for the future.

SEVENTH DISTRICT

Bernard J. Emkes, M.D., John M. Records, M.D., and Ronald K. Stegemoller, M.D., trustees

In the face of health system reform, the Seventh District membership continues to increase, proving that physicians appreciate the value of organized medicine.

As in past years, several members of the Seventh District served as "Doctor of the Day" at the Statehouse during the legislative session, a program co-sponsored by the ISMA and the Indiana Academy of Family Physicians. The Seventh District also was well-represented during an ISMA trip to Washington, D.C., for personal visits with legislators.

Paula A. Hall, M.D., Seventh District president, welcomed an enthusiastic crowd to this year's annual meeting at Conner Prairie, where everyone enjoyed the Indianapolis Symphony Orchestra. It was especially gratifying to see many new members and their families attend.

Dr. Hall spoke on the importance of joining IMPAC and participating in the "Dollar-A-Day" program, initiated by William H. Beeson, M.D., immediate past president and Seventh District member.

ISMA President William VanNess II, M.D., encouraged physicians to be more active in their organizations, and ISMA Alliance President Sue Ellen Greenlee urged spouses to become more involved in their alliance.

The Seventh District continues to be well-represented at the ISMA by Peter L. Winters, M.D., ISMA speaker of the House of Delegates, and Dr. Beeson. We acknowledge their efforts and service to all members of the Seventh District.

We conclude our report with

this year's election results: Russell L. Judd, M.D., president-elect; John F. Schneider, M.D., secretary-treasurer; Bernard J. Emkes, M.D., trustee; and Paula A. Hall, M.D., alternate trustee.

Craig A. Moorman, M.D., a Johnson County pediatrician, assumed his office as Seventh District president after the annual meeting. We are confident that the district will be in equally good hands this year as we anticipate health system reform.

Congratulations to all of the newly elected and re-elected officers of the Seventh District.

EIGHTH DISTRICT

John V. Osborne, M.D., trustee

The Eighth District officers met throughout the year, and the annual meeting was held June 1 at the Delaware Country Club in Muncie. Susan Pyle, M.D., president of the Randolph County Medical Society and the Eighth District, conducted the meeting.

The 1993 minutes were read and approved.

Kathleen Galbraith, M.D., from Jay County, was elected president-elect. Susan Pyle, M.D., was re-elected alternate trustee for the next three years.

Other old business was discussed.

After dinner, William VanNess II, M.D., ISMA president, led a discussion on health system reform. Sen. Allen Paul, representing sections of Jay, Randolph and Wayne counties, and John Bailey, M.D., Indiana state health commissioner, also spoke on the issue.

For entertainment, a one-act melodrama was presented by the Randy Players. Door prizes and golf awards were given.

The next meeting will be June

7, 1995, hosted by the Jay County Medical Society. The location will be announced later.

NINTH DISTRICT

Stephen D. Tharp, M.D., trustee

The Ninth District is pleased to continue its tradition of service to members again this year.

The 1994 annual meeting was held June 8, and was hosted by the Tippecanoe County Medical Society with Irene Gordon, M.D., serving as Ninth District president.

In keeping with the growing concerns of our members, this year's program was presented by Maureen Schick, AMA policy analyst. She summarized the myriad of health proposals circulating around the state and the nation. We were particularly heightened by the news that the administration seems to be listening to organized medicine a little more attentively and that we as physicians have the ability to affect the coming political changes.

William VanNess II, M.D., ISMA president, and John Knotte, M.D., AMA delegate, gave their insights on the political process. We also were pleased to have Sue Ellen Greenlee, ISMA Alliance president, and Darlene Haddawi, ISMA Alliance president-elect, at the meeting.

Although the Ninth District can hardly take credit for his success, we are proud that Tim Brown, M.D., ISMA treasurer, has weathered the primary election and will be running for election to the Indiana House of Representatives in November. I am sure you are well aware of Dr. Brown's accomplishments and service to the ISMA, and we look forward to his contributions at the Statehouse.

This year has brought us face

to face, even more than ever, with the likelihood of significant changes in medicine. The Ninth District members will work diligently to make sure that the coming changes will keep patients as the primary focus.

I am pleased to have been re-elected trustee of the Ninth District and look forward to continued service.

10TH DISTRICT

Thomas Brubaker, M.D., trustee

The 10th District meeting was held April 30. The main speaker was Congressman Steve Buyer from the Fifth Congressional District. He was dynamic and supportive of many of our views on health care reform. The meeting was preceded by a fundraising effort on behalf of the Congressman by interested parties.

Support of our efforts by the Physicians Insurance Co. of Indiana and Affiliated Physicians Services Inc. was invaluable. Several ISMA officers and staff also attended, and their comments were appreciated. Sen. Rose Antich also attended the meeting and spoke with physicians.

The following officers were elected for 1994-95: Frank Hieber, M.D., president; Floyd Manley, M.D., secretary/treasurer; and John Swarner, M.D., alternate trustee.

Dues for the 10th District were raised to help defray the expenses of sending delegates to the ISMA annual convention.

The 1995 district meeting will be April 29, 1995, in Lake County.

As trustee, I have spoken with many legislators regarding ISMA policies and have found them to be open to our grassroots efforts. I hope to develop these contacts

further by holding a legislative forum for all of our legislators in September. I plan to have physician experts speak on key legislative issues.

12TH DISTRICT

Joseph R. Manthey, M.D., trustee

I first wish to welcome Kosciusko County to the 12th District and look forward to their active participation in our activities. I want to thank John Thomas, M.D., ISMA vice speaker of the House of Delegates, and Fort Wayne Medical Society Executive Director Win Rood for their continued advice and support.

The 12th District, along with its component alliance, remains politically active, meeting with both state and federal legislators. I see this time as an extraordinary opportunity to educate the public about the real factors underlying health care expenditures. I also welcome this time to demonstrate the key role of physicians as patient advocates.

As trustee, it is my duty and pleasure to serve all members. I encourage all questions and concerns and pledge to work diligently on your behalf.

13TH DISTRICT

Alfred C. Cox, M.D., trustee

The 13th District's annual meeting was held March 23 at Amish Acres in Nappanee. The date of the annual meeting was changed to earlier in the year so the district could discuss legislative issues while the Indiana General Assembly was in session.

This year's meeting topic was health care reform, including a discussion of the ISMA health care

■ annual reports

plan. Donald Smith, M.D., of South Bend was elected district president, and Jack Schurz, M.D., of South Bend was re-elected secretary-treasurer. Richard Houck, M.D., of Michigan City, was re-elected alternate trustee.

The rest of the afternoon was spent play acting, solving a murder mystery and enjoying an Amish dinner. The next district meeting will be in March 1995 in South Bend.

COMMISSION ON CONSTITUTION & BYLAWS **Fred W. Dahling, M.D., chairman**

The Committee on Constitution & Bylaws did not meet formally this year. Bylaws changes, mandated by the passage of Resolutions 93-2, 93-4 and 93-44 during the 1993 ISMA annual convention, were incorporated into the ISMA bylaws by Ron Dyer, ISMA general counsel, and his staff. The bylaws were approved by the members of the committee by mail ballot.

The updated version of the *1994 ISMA Constitution & Bylaws*, as distributed to the House of Delegates, will serve as the formal report from the committee.

COMMISSION ON LEGISLATION **Barney Maynard, M.D., chairman**

The Commission on Legislation saw another very successful year in 1994. The "short" session of the Indiana legislature began in January with the clear understanding that there would be little effort to make major policy in any area. For medicine, this provided a bit of reprieve, allowing us time to continue work on our own efforts in health system reform and to

await the mandates that will come from Washington later this year. Nonetheless, there were issues to be addressed and a couple of major efforts to be made.

Of major concern was still another effort to remove "any willing provider" language from the statutes that govern PPOs. Through a strong grassroots effort of physicians and ISMA Alliance members, several physicians who personally lobbied this issue and the dedication of the ISMA legislative staff, the current language was retained. As an additional benefit, the efforts of our legislative staff placed us in an excellent light with the legislators because we not only fought this one on our own, but we came away looking like the one interest that is willing to negotiate and find a compromise with which everyone can live. Quite a feat!

Also of importance to the medical community was the passage of legislation that allows citizens in their living wills to make advance directives regarding artificial hydration and nutrition. Not only was this legislation passed after several years of effort, but it allowed the ISMA to interact with some seniors' groups that also may find common ground with the ISMA regarding health system reform.

Perhaps the highlight of the legislative year for the ISMA resulted not from our efforts, but from the voters of the 41st District of the Indiana House of Representatives. The successful bid of Timothy Brown, M.D., ISMA treasurer, in the Republican primary for the vacated seat of Rep. Pool must stand as a major event of 1994. As of this writing, we fully expect Dr. Brown to win his seat in the House in November and become the "doctor in the House" for the 1995 and 1996

legislative sessions. At this critical juncture for the future of the physician/patient relationship and the medical profession, it is truly exciting to know that we may have a colleague where the action will be. The Commission on Legislation wishes to thank and honor Dr. Brown for making this extraordinary act of citizenship and to the many physicians around the state who helped support Dr. Brown's efforts.

I wish to take this opportunity to publicly thank and commend our ISMA legislative staff. I have spoken to several legislators during the past year, and it is the universal opinion that our staff has positioned the ISMA to be not only an enormous force regarding health care but that our staff has become one that is looked upon not only with respect but as people who are honest and reliable.

My sense is that the ISMA has been positioned to be a voice of reason and strength in the health care arena. My sense is also that our legislators are fully aware that the physicians will view any changes in our health system through the lens of the physician/patient relationship. We will support what is good for that relationship, and we will vigorously oppose what is bad for that relationship.

So I personally and publicly thank Mike Abrams, ISMA director of government relations; Lou Belch, assistant director of government relations; and Katherine Vaughn, legislative assistant, for their work. This is a staff for which the physicians of Indiana can be extremely proud.

COMMISSION ON MEDICAL EDUCATION

Glenn Bingle, M.D., chairman

The Commission on Medical Education and the Subcommittee on Accreditation met Nov. 4, 1993, and May 22, 1994. Stephen Jay, M.D., and Don Dion, M.D., remain chairman and vice chairman. In August, I was appointed chairman of the commission after the resignation of James Carter, M.D. Dr. Jay was named the acting vice chairman of the commission after the death of Robert Warren, M.D., of Richmond.

We have welcomed two new members – Martha Mechei, M.D., from Crown Point and Mark DeRoo, M.D., from West Lafayette. We still have vacancies from the Fourth and Sixth districts. Attendance at the subcommittee meetings is superb, between 85% and 90%; whereas attendance at commission meetings of 50% may indicate a need for change.

During the last six years, we have involved members of the subcommittee in surveying the institutions and organizations for CME accreditation. Their personal involvement in the work of the subcommittee may speak to their ownership of the subcommittee's work and may require us to evaluate the role of both bodies. Members already have expressed a desire to evaluate the day and time of the meeting, which has been the same for more than 20 years.

This year, we have completed 15 to 30 scheduled resurveys. This represents many man hours of voluntary physician survey time and documentation hours. We have reaccredited nine hospitals and six specialty societies. This includes two new organizations – the National Kidney Foundation of Indiana and the Indiana Academy

of Ophthalmology.

The subcommittee has expressed concern about the burden of excessive paper documentation required to meet the essentials for CME accreditation and is pledged to try to reduce this burden through feedback through its leadership to the Accreditation Council on Continuing Medical Education. Moreover, the subcommittee reviewed the White Paper, titled "The Connection Between Continuing Medical Education and Health Care Reform," co-authored by Dr. Jay, who is co-chair of the national Task Force on CME & Health Care Reform. We also received the resolution of the Alabama Medical Association in support of the tenets of the paper.

Implementation of the New Guidelines for Commercial Support for CME have presented the commission with a new challenge. Annual reports would indicate substantial compliance, with 75% of programs responding. These guidelines have led to misunderstanding and some confusion and have necessitated a marked educational effort and defining the process for complaint handling on behalf of the subcommittee.

With health care reform legislation proposing that graduate medical education be directed to produce at least 50% of graduating residents in primary care, the commission received reports from the Indiana University School of Medicine, noting increasing interest and enrollment in primary care residencies throughout the state and progress on the Primary Care Initiative, led by Steve Bogdewic, Ph.D., associate dean for primary care education. Of Indiana's 254 PGY-1 matched positions in the National Resident Matching Program, approximately

58% were in the fields of family and internal medicine, pediatrics and obstetrics and gynecology. Significant contributing factors include the new family practice rotation in the third year of medical school and recognition by students of changing opportunities in primary care versus subspecialty care.

The members of the commission and subcommittee thank Dotty Martens and other ISMA staff who have provided us with excellent support throughout this year.

COMMISSION ON PHYSICIAN ASSISTANCE

Robert Nelson, M.D., chairman

This year has been productive and busy for the Commission on Physician Assistance. In February, we sponsored the first-ever Medical Marriages seminar, held in Lafayette in conjunction with the ISMA Alliance. Various workshops were conducted on issues medical couples and medical families face.

We have continued our work with the Indiana Hospital Association, and we have seen an increase in the number of inquiry calls we get directly from hospital administrators. Candace Backer, the program coordinator, spoke at several district meetings of hospital administrators. Her talks have been a valuable educational tool, allowing for informal question-and-answer sessions and providing an opportunity to encourage hospitals to evaluate and implement physician assistance programs within their hospitals.

Our work with the Indiana University Physician Assistance Program also has continued. Program staff have continued to

■ annual reports

give presentations to all major departments regarding committee services.

The commission continues to investigate new cases and monitor existing ones. We are monitoring 80 cases in the state. We have seen an increase this year to 14 referrals from hospital-based physician assistance committees. Although we continue to see a high number of chemically dependent physicians, we have also seen an increase in the number of dually diagnosed cases. Family practice and emergency room physicians continue to be the specialties we see most frequently.

COMMISSION ON SPORTS MEDICINE

George M. Underwood, M.D., chairman

The Commission on Sports Medicine was active throughout 1994.

The commission added a sports attorney and a representative from the Indiana State Department of Health, Division of Oral Health.

Guidelines on concussions, heat illnesses, weight loss among high school wrestlers, brachial plexus injuries, upright lateral knee bracing and cervical spine injuries were reviewed and updated. These guidelines will be available to all athletic trainers, team doctors and other medical personnel for IHSA schools.

A subcommittee of the commission is revising the IHSA sports medical form and will

present it to the IHSA by the end of 1994. It includes a medical questionnaire and a more comprehensive physical form.

As chairman, I thank the committee members for their participation and interest.

GRIEVANCE COMMITTEE

Richard B. Schnute, M.D., chairman

The Grievance Committee, including Max Hoffman, M.D.; Freeman Martin, M.D.; John Pless, M.D.; Susan Pyle, M.D.; and John Seward, M.D., investigated multiple complaints during the 1993-94 period and worked diligently to fairly resolve these issues.

Complaints included differences of opinion concerning diagnosis and treatment, fees and charges and accusations of improper deportment. Most misunderstandings resulted from inadequate communication or explanations. The committee strongly urges better communications between physicians and patients.

As chairman, I thank the committee members for their participation in resolving these problems.

INDIANA MEDICINE

George T. Lukemeyer, M.D., editorial board chairman

The editorial board of *INDIANA MEDICINE* reviewed 19 manuscripts from Aug. 1, 1993, to July 31, 1994.

The board is continuing its policy of having all scientific manuscripts reviewed by one or more members of the editorial board to determine their acceptability for publication. Many articles are also submitted to outside reviewers for their evaluation and recommendations.

I would like to thank the following editorial board members for their assistance in reviewing manuscripts: James R. Buechler, M.D., Terre Haute; Thomas J. Conway, M.D., Terre Haute; James W. Edmondson, M.D., Indianapolis; Robert L. Forste Jr., M.D., Columbus; Panayotis G. Iatridis, M.D., Gary; George C. Manning, M.D., Fort Wayne; and Bruce F. Waller, M.D., Indianapolis. I also appreciate the participation of Franklin Roesner and Holly Mattix, the medical students whose terms on the board ended Dec. 31, and Theresa Bayt and John Joven, the current student representatives.

Effective this year, *INDIANA MEDICINE* will publish annually an outstanding medical paper written by a student at the Indiana University School of Medicine and present the student \$500 and the Frank B. Ramsey Award. The editorial board recommended the annual publication of a student paper and proposed naming the award in memory of Frank B. Ramsey, M.D., the editor of *INDIANA MEDICINE* from 1949 to 1990. The medical school faculty will select the three finalist papers, which will then be reviewed by the editorial board to determine the award winner. □

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■ resolutions

Status of 1993 resolutions

RESOLUTION 93-1

Prohibit Corporal Punishment in Indiana Schools

Introduced by:

John Luce, M.D., LaPorte County

Referred to:

ISMA Commission on Legislation and ISMA Legislative Department

Status:

No legislation introduced during short session. Can be pursued during 1995.

RESOLUTION 93-2

Indemnification of Officers & Trustees

Introduced by:

ISMA Executive Committee

Referred to:

ISMA Commission on Constitution and Bylaws

Status:

Will be added to constitution and bylaws at next printing.

RESOLUTION 93-3

Death With Dignity

Introduced by:

James Reidy, M.D., Charles Walters, M.D., and St. Joseph Medical Society

Referred to:

ISMA Commission on Legislation and ISMA Legislative Department

Status:

Living will legislation passed.

RESOLUTION 93-4

Speaker & Vice Speaker of the House of Delegates

Introduced by:

ISMA Executive Committee

Referred to:

ISMA Commission on Constitution and Bylaws

Status:

Will be added to constitution and bylaws at next printing.

RESOLUTION 93-5

Restrictive Covenants/AMA Ethics/Indiana Law

Introduced by:

Alvin Haley, M.D.

Referred to:

ISMA general counsel for inclusion in policy manual (first and second resolve), Indiana delegation to the AMA (third resolve) and Board of Trustees (fourth resolve)

Status:

Implemented into ISMA policy manual. Resolution 93-1 was introduced at the

December 1993 AMA meeting where it was "not adopted."

RESOLUTION 93-6

Integrated Health Education for Adolescents

Introduced by:

Adolescent Preventive Health Care Task Force

Referred to:

ISMA Board of Trustees

Status:

The ISMA is participating in a survey designed to measure the willingness of physicians to participate in advocacy programs for school health education. The survey results will be used to plan a program designed to help doctors advocate for an integrated school health education program as part of community coalitions focused on adolescent health. The program, a cooperative effort between the ISMA and the Indiana Chapter of the American Academy of Pediatrics, is scheduled for Oct. 15, and will incorporate House of Delegate directives in Resolutions 93-10 and 93-12.

RESOLUTION 93-7

Smoking Ban for Adolescents

Introduced by:

ISMA Adolescent Preventive Health Care Task Force

Referred to:

ISMA Commission on Legislation and ISMA Legislative Department

Status:

Legislation failed during 1994 session.

RESOLUTION 93-8

Bicycle Helmets

Introduced by:

ISMA Adolescent Preventive Health Care Task Force

Referred to:

ISMA Commission on Legislation and ISMA Legislative Department

Status:

No legislation introduced in 1994 session.

RESOLUTION 93-9

Introduced by:

Referred to:

Status:

School-Linked Health Care Programs

ISMA Adolescent Preventive Health Care Task Force
ISMA Communications Department

Letter was sent to all school superintendents, the Indiana State Department of Health and the Indiana Department of Education indicating the ISMA's policy on school-based and school-linked clinics. The policy also will be added to the ISMA's policy manual.

RESOLUTION 93-10

Introduced by:

Referred to:

Status:

Community Coalitions Focused on Adolescent Health

ISMA Adolescent Preventive Health Care Task Force
ISMA Communications Department and ISMA Alliance Liaison

See status for Resolution 93-6.

RESOLUTION 93-11

Introduced by:

Referred to:

Status:

In-School Screenings for Children at Risk for Certain Psychiatric Illnesses

ISMA Adolescent Preventive Health Care Task Force
ISMA Board of Trustees
Feasibility report was provided at the March board meeting and taken for information.

RESOLUTION 93-12

Introduced by:

Referred to:

Status:

Physical Fitness Programs for Adolescents

ISMA Adolescent Preventive Health Care Task Force
ISMA Communications Department and ISMA Alliance Liaison

See status of Resolution 93-6.

RESOLUTION 93-13

Introduced by:

Referred to:

Status:

Hospital Staff Consultation in Suspected Terminal Cases

George Rawls, M.D., and Indianapolis Medical Society

ISMA legal counsel and Indiana delegation to the AMA

Resolution 93-807 was introduced at the December 1993 AMA meeting where AMA Policy 140.995, Hospital Ethics Committees, was reaffirmed in lieu of our resolution.

RESOLUTION 93-14

Introduced by:

Referred to:

Status:

Regulation of Electronic Signature Process

Indianapolis Medical Society

ISMA legal counsel and Indiana delegation to the AMA

Resolution 93-818 was introduced at the December 1993 AMA meeting and the House referred it to the ISMA Board of Trustees for decision.

RESOLUTION 93-15

Introduced by:

Referred to:

Status:

CLIA Legislation

District 4

ISMA Legislative Department

A fourth category of testing was adopted to accommodate some of the criticisms of CLIA. Further efforts to mitigate CLIA hassles will likely be discussed at the federal level as health reform is discussed.

RESOLUTION 93-16

Introduced by:

Referred to:

Status:

Medical Explorer Posts

Monroe/Owen County Medical Society and District 2

ISMA Field Staff Representatives

List of established medical explorer posts and their

■ resolutions

coordinators is being compiled by ISMA staff.

RESOLUTION 93-17

Introduced by:

Referred to:

Status:

U.S. Surgeon General

Bernard Emkes, M.D.

ISMA Legislative Department and Indiana delegation to the AMA

Letters were sent to all members of the Indiana Congressional delegation regarding this issue. Resolution 93-211 was introduced at the December 1993 AMA meeting and the following Substitute Resolution 93-211 was adopted in lieu of our resolution:

"Resolved, That, in order to best protect the health care needs of the American people, the AMA seek changes in federal law to require that the Surgeon General of the United States be a physician, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis."

RESOLUTION 93-18

Introduced by:

Referred to:

Status:

Initial RMS Membership Dues

Resident Medical Society
ISMA Accounting Department

Implemented \$50 one-time dues fee for residents to cover membership for entire residency program.

RESOLUTION 93-20

Introduced by:

Referred to:

Status:

Family Violence – Amending the State Marriage License Application

ISMA Board of Trustees and ISMA Alliance

ISMA Board of Trustees
Feasibility report was provided at March board meeting and taken for information.

RESOLUTION 93-21

Introduced by:

Referred to:

Status:

Family Violence – Amending the State Birth Certificate

ISMA Board of Trustees and ISMA Alliance

ISMA Board of Trustees
Feasibility report was provided at March board meeting and taken for information.

RESOLUTION 93-22

Introduced by:

Referred to:

Status:

ISMA Recruitment Policies

ISMA Membership Task Force

ISMA Marketing Department

The ISMA has conducted programs for residents in Fort Wayne, South Bend and one is planned for Indianapolis. The ISMA Membership Task Force continues to explore ways in which we can reach out to women and minority physicians.

RESOLUTION 93-23

Introduced by:

Referred to:

Status:

Due Process, Fair Hearing & Release of Selection Criteria by Preferred Provider Organizations

Vanderburgh County Medical Society

ISMA Commission on Legislation and ISMA Legislative Department

House Bill 1322, the vehicle for this language, was not adopted.

RESOLUTION 93-24A

Introduced by:

Referred to:

Status:

Retention of "Any Willing Provider" Language

Vanderburgh County Medical Society

ISMA Commission on Legislation and ISMA Legislative Department

Legislation to delete the "any willing provider" protection was defeated during 1994 session.

RESOLUTION 93-25

Introduced by:

Referred to:

Status:

Support of AMA Anti-Trust Relief Efforts
Vanderburgh County Medical Society
ISMA legal counsel
AMA has been working with U.S. Justice Department to develop new guidelines, expected to be published in October or November.

RESOLUTION 93-26

Introduced by:

Referred to:

Status:

Civil Immunity Law
George Underwood, M.D.
ISMA Board of Trustees
A report was provided at the March board meeting that indicated that current state law does not give immunity to any health care providers giving volunteer care for sports and leisure activities. Carving out an exception for physicians only to the exclusion of other health care providers would be extremely difficult to explain to the legislature. The board took the report for information and did not pursue legislative action.

RESOLUTION 93-27

Introduced by:

Referred to:

Status:

Physical Laboratory Fee Reimbursement
Third District Medical Society
ISMA legal counsel
Will send letter advocating that reimbursement for lab services reflect the true costs of complying with government mandates.

RESOLUTION 93-28

Introduced by:

Referred to:

Status:

Quality Lab Testing in Physician Offices
Third District Medical Society
ISMA legal counsel
Representatives from OSHA and Indiana State Department of Health will be invited to ISMA Medicare

RESOLUTION 93-29

Introduced by:

Referred to:

Status:

Coalition meeting to discuss issues as required.

Standardization of Managed Care Office Safety Standards

Indianapolis Medical Society

Indiana delegation to the AMA

Resolution 93-702 was introduced at the December 1993 AMA meeting. The House adopted the following Substitute Resolution in lieu of our resolution:

"Resolved, That the AMA oppose duplicative efforts by managed care organizations to develop physician office safety standards that have already been implemented by federal and/or state regulation; and be it further

Resolved, That the AMA urge the Joint Commission on Accreditation of Health Care Organizations, the National Committee on Quality Assurance, the Accreditation Association for Ambulatory Health Care, and other relevant accreditation organizations to seek greater simplification and standardization of such office review efforts as a means of reducing health care costs and unnecessary burdensome paperwork for physicians and their employees."

RESOLUTION 93-30

Introduced by:

Referred to:

Safety of Young Children

Indianapolis Medical Society
ISMA Commission on Legislation and ISMA Legislative Department

■ resolutions

Status: Legislation introduced in 1994 (SB 143) but not adopted.

RESOLUTION 93-34

Statewide Managed Care Models

Introduced by: Lake County Medical Society

Referred to: ISMA legal counsel

Status: The ISMA will provide model contracts prepared by AMA Office of General Counsel, on request.

RESOLUTION 93-36

Patient Compensation Fund Surcharge

Introduced by: Lake County Medical Society

Referred to: ISMA policy manual for inclusion

Status: Implemented into the ISMA policy manual.

RESOLUTION 93-37

Sample Legislative Letters

Introduced by: Warrick County Medical Society

Referred to: ISMA Board of Trustees
Status: Report was provided at the March board meeting and recommendations will be implemented.

RESOLUTION 93-38

Delegation of Physician's Responsibility to Paramedical Personnel

Introduced by: Elaine Hathaway, M.D.

Referred to: ISMA Board of Trustees

Status: The topic has been discussed at length during several board meetings and was scheduled for the July 31 agenda.

RESOLUTION 93-39

ISMA Training for County Officers

Introduced by: Regino Urgena, M.D.

Referred to: ISMA Board of Trustees

Status: A survey of county medical society officers is being conducted to determine specific program interests.

RESOLUTION 93-40

ISMA Health System Reform Plan

Introduced by: ISMA Health System Reform Task Force

Referred to: ISMA Commission on Legislation and ISMA Legislative Department

Status: Plan distributed to all Indiana legislators.

RESOLUTION 93-41

Employer-Mandated Health Insurance

Introduced by: John MacDougall, M.D.

Referred to: ISMA policy manual for inclusion and Indiana delegation to the AMA

Status: Implemented into the ISMA policy manual. Resolution 93-104 was introduced at the December 1993 AMA meeting. The House adopted Board of Trustees' Reports 40, 41 and 60, as amended, in lieu of the resolution.

RESOLUTION 93-42

Health Care Savings Account

Introduced by: John MacDougall, M.D.

Referred to: ISMA policy manual for inclusion and Indiana delegation to the AMA

Status: Resolution 93-105 was introduced at the December 1993 AMA meeting. The House adopted Board of Trustees' Reports 40, 41 and 60, as amended, in lieu of the resolution.

RESOLUTION 93-43

Opposition to a National Health Board

Introduced by: John MacDougall, M.D.

Referred to: ISMA policy manual for inclusion and Indiana delegation to the AMA

Status: Implemented into the ISMA policy manual. Resolution 93-107 was introduced at the December 1993 AMA meeting. The House

adopted the following Substitute Resolution 107:

"Resolved, That the American Medical Association reaffirm its Policy 165.960(C)(1) in opposition to a national health board of the sort currently proposed by the Administration."

Substitute Resolution 107 also amended Policy 165.945(1)(d) as follows:

"The AMA support the creation of national health advisory body or task force that will form a public/private partnership including the AMA to recommend health policy."

RESOLUTION 93-44

Introduced by:

Referred to:

Status:

Change in District

Kosciusko County ISMA Members

ISMA Commission on Constitution and Bylaws and ISMA Membership Department

Implemented into membership dues structure and will be added to the constitution and bylaws at next printing.

RESOLUTION 93-45

Introduced by:

Referred to:

Status:

Physician Grassroots Political Action

William Beeson, M.D.

ISMA Board of Trustees and IMPAC Board

The IMPAC Task Force met on March 16 and felt that the newly restructured IMPAC Board deserved a chance to function and did not observe a need to recommend any action at that time. Dollar-A-Day program implemented at convention and has 40 members to date. □

A one-year review of the Eye Injury Registry of Indiana

William L.F. Harvey, B.A.
Ronald P. Danis, M.D.
Indianapolis

Injuries to the eye are a significant source of morbidity. National estimates of ocular injury range from 1 million to 2.4 million annually.¹ Eye injuries are second only to cataracts as the most common cause of visual impairment, with approximately one in 20 patients visiting an ophthalmologist secondary to eye injury.²

The national average annual rate of hospitalization from 1984 to 1987, based on national hospital discharge surveys, was 13.2 per 100,000 people.¹ In one review of eye trauma in Dane County, Wis., the incidence of acute hospital-treated injuries was 423 in 100,000.³ More common causes of eye injury include assaults, work-related events, sports and recreational activities, falls and motor vehicle crashes.^{1,3}

National surveys show males are more likely to be injured than females, with a large proportion of serious trauma occurring in people younger than 25 years of age. Although national eye trauma registries have existed for several years, Indiana has not had similar means to record eye injuries. Therefore, in June 1992, the Eye Injury Registry of Indiana (EIRIN), sponsored by the Indiana

Abstract

In the first year of operation, the Eye Injury Registry of Indiana collected data on 171 severe eye injuries and categorized them according to the circumstances of the injury, severity of tissue disruption and visual function. Many preventable causes of injury were documented. By understanding the contributors of accidental injury, prevention strategies can be implemented. This collaborative project should continue to provide useful information specific to Indiana concerning the root causes of eye injury.

Academy of Ophthalmology, was initiated to document and record the types of eye trauma sustained in Indiana for educational and scientific study. The first 171 cases of eye injuries reported by state ophthalmologists to the EIRIN during the first 12 months of its operation are analyzed.

Methods

Registry data forms are sent from the central office to ophthalmologists throughout Indiana. Ophthalmologists are asked to document injuries when they occur and return the forms. Information requested in the initial report form includes: coded identification of the individual and the eye(s) injured; use of eye protection; place of injury; work, sports or other related activities; alcohol/drug use; bystander status and intention (i.e., assault vs. acciden-

tal); type of injury (i.e., burn, blunt, penetrating, etc.); type of ocular tissue involved; best visual acuity; initial diagnosis; and initial operation if required. This information is stored on a D-Base IV data base on a desktop computer. Only those injuries likely to result in permanent functional or structural compromise of the eye are included in the data base. The EIRIN also sends out a six-month follow-up report to evaluate the patient's progress since the initial insult. During the first 12 months, 171 eye injuries were reported to the EIRIN with 35 six-month follow-up reports.

Results

Injuries occurred predominantly to younger individuals (79% younger than 40 years of age) and males (83%). The severity of injury among registry cases is re-

flected in the initial visual acuity, with nearly one-third of patients having severe vision loss (*Figure 1*). In 78% of the cases, patients were not using eyewear at the time of injury (*Figure 2*), and in only two cases were safety glasses worn. The patient was reported as a bystander at the time of injury in 28 cases (16.37% of total). In the eight reported cases of injuries secondary to fireworks, seven occurred to bystanders.

Work-related injuries were reported in 35 cases (20.5% of total), with industrial accidents occurring in 19 of the 35, and farming injuries in 5 of the 35. The most common place of injury was at home (40%), followed by sports facilities (15%), workplace (14%), streets and highways (10.5%), and unknown (10.5%). The 171 injuries were predominantly unintentional (78.4%) versus assault (14%), with alcohol involved in 20 of the 171, and no reported cases of associated drug use.

The source of injury included many preventable causes (*Figure 3*). BB guns were involved in 12 cases (6.43%), resulting in visual acuity of 20/100 or worse in eight patients. Fireworks accounted for eight injuries. Other categories included 22 cases of sharp objects (i.e., wood chips, metal fragments, pencils), 32 cases of blunt objects (fist, bats, tree branches, shoes), and 12 burns.

In the 26 cases of sports-related ocular injury (*Figure 4*), almost one-quarter (6/26) were caused by baseballs. In all cases of baseball injury, eye protection was not used. Basketball injuries were associated with fingers or hands poking in to the eye. Three injuries occurred each from golf balls and racquetballs respec-

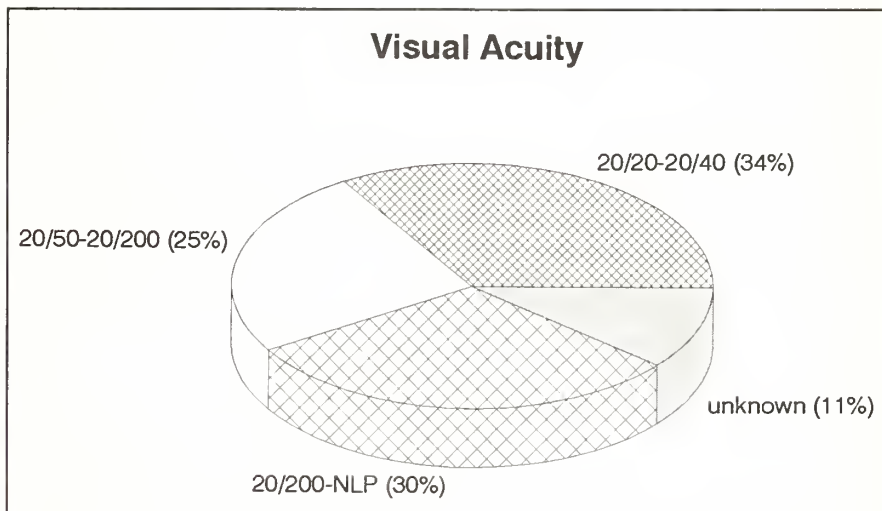


Figure 1

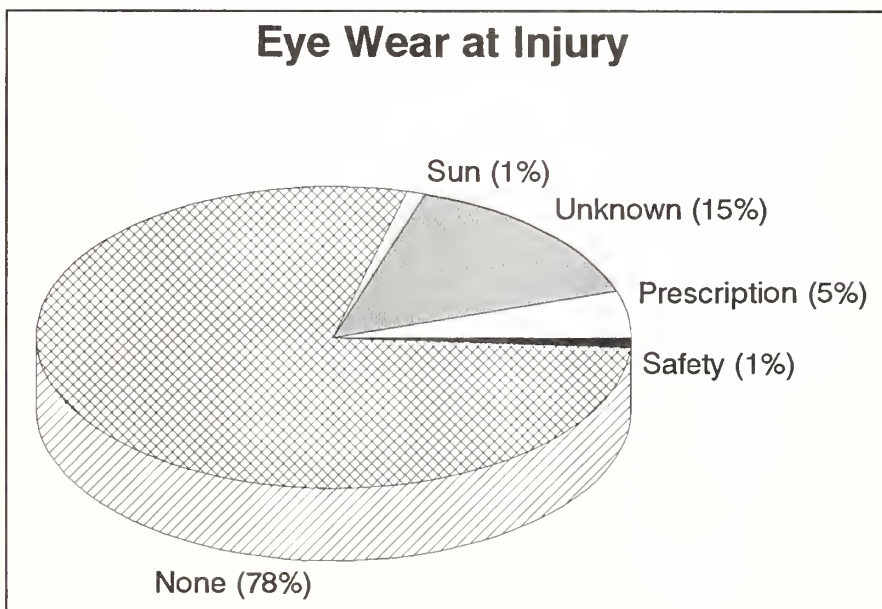


Figure 2

tively. Four injuries resulted from accidental fishing hook penetration of the eye while casting. In one of these cases, acute endophthalmitis was a sequela.

Lacerations were the most

common injury to the lids, lacrimal system, cornea, sclera and iris. Corneal burns, predominately alkaline, accounted for 41% of corneal injuries. Only 18.3% of all registered injuries involved the

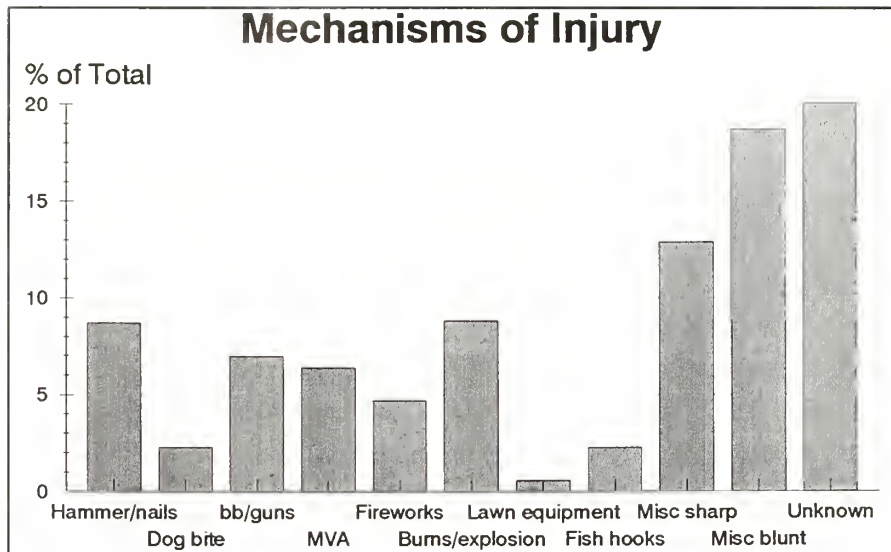


Figure 3

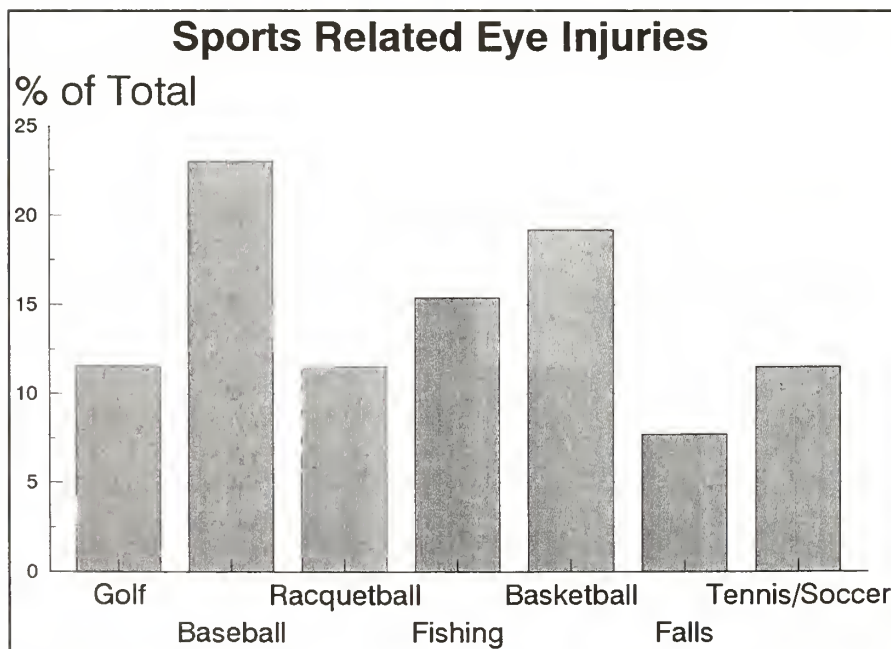


Figure 4

lens, but of those injuries, 26% had complete or partial dislocation, and 74% resulted in traumatic cataracts. Forty-two injuries (25%) occurred to the anterior chamber with hyphema reported

56% of the time.

Nearly 25% (42/171) of all cases reported were severe enough to involve the vitreous and/or retina. There were 27 cases of vitreous hemorrhage and

nine cases of vitreous penetration. There were 10 cases of retinal detachment, with retinal tears and hemorrhages in an additional eight and nine cases, respectively. Injury resulted in retinal edema involving the macula in three cases. The remaining cases of trauma include five orbital fractures, eight choroidal hemorrhages and one incidence of extraocular muscle damage.

Follow-up six-month reports have been reviewed for 35 cases (22%) of the initial 171. The low response is consistent with the one-year age of the Indiana registry, in which most cases have been reported in the last six to eight months.

Discussion

Ocular injuries in Indiana from June 1, 1992, to May 31, 1993, were primarily due to accidental injury. Many of these accidents were the result of potentially preventable causes such as fireworks, BB guns, sports-related injuries and occupational injuries.

In Indiana, eight ocular firework injuries were reported to the injury registry from June 1992 to June 1993. Seven of eight involved bystanders, six of eight were under 16 years of age, and all caused blunt trauma with either hyphemas, vitreal-retinal hemorrhages or lacerations. Most injuries occurred to young men who are unsupervised and not wearing protective eye wear. Seven were secondary to bottle rockets. In a study of firework-related injuries by the Marion County Health Department for Marion County, Ind., between 1986 to 1991, 159 people were injured.⁴ Sixty-eight percent of these injuries occurred to people younger than 25 years of age. The second most common site of in-

jury after hand injuries involved the eyes (38/159 people).⁵ In view of the frequent severe nature of ocular injuries from fireworks, the retail sale and possession of fireworks should be carefully regulated.

BB or air gun injuries are significant sources of severe ocular injuries with generally poor outcomes, often despite extensive surgery to save useful vision.⁶⁻⁹ Ocular injuries are most often penetrating and involve the posterior segment of the eye. The unusual severity of ocular trauma from BBs is out of proportion to the size of the pellets and may be related to compressive or shearing forces inside the vitreous and retina. This fact is often not appreciated by the general public, and air guns are frequently marketed toward teenagers and children who are less likely to exhibit responsibility in handling them.⁹ In the 12 cases of BB gun injuries reported to the EIRIN, all 12 patients were males and under 16 years of age. Eight of the 12 required surgery, including five with removals of intraocular foreign bodies and two enucleations. To prevent these kinds of injuries, protective eye wear should be strongly encouraged, and greater parental supervision exercised.

Sports and recreational activities are a frequent source of eye injury. The mechanism of injury depends on the type of activity; however, sports involving balls of any size are potentially dangerous. Sports most commonly associated with eye injuries include baseball or softball, basketball, racquetball, squash, golf and ice hockey.³ In our review of injuries, baseball, basketball and fishing were the three most common

sources of sporting injuries. Of the six baseball or softball injuries, two suffered orbital fractures requiring repair, three had hyphemas and one had retinal involvement. Five of the six baseball injuries occurred while at bat, with one injury sustained after misplaying a ground ball. Ocular trauma could potentially be reduced if batters were required to wear eye/face protection in addition to the already mandatory hard baseball caps.

Eleven of 35 work-related injuries reported to the EIRIN occurred while hammering nails, and eight of 35 involved chemical alkaline burns to the cornea or sclera. The National Eye Trauma System Registry reported 635 of 2939 (22%) penetrating injuries as occupationally related.¹⁰ The most common mechanisms of injury were metal or wood foreign bodies and chemical spills or splashes. The most frequent activity was hammering or chiseling on metal.

Safety glasses are essential in the prevention of eye injury in work settings where chemical spills or projectiles are a potential risk.

Many of the ocular injuries reported to the EIRIN during its first year of operation could have been prevented if caution and forethought had been exercised. The frequently severe nature of ocular injuries from sports, fireworks and BB guns can be reduced if appropriate state and parental intervention is exercised. Occupational conditions that have the potential for eye injury, especially those with metal or wood projectiles, can be avoided by the routine use of safety glasses.

The EIRIN will continue to receive and record ocular trauma

data. The knowledge gained will be used to prevent future injuries and vision loss in Indiana through educational programs and for use as a public resource. □

Harvey is a fourth-year medical student at the Indiana University School of Medicine. Dr. Davis is with the Department of Ophthalmology at the IU School of Medicine in Indianapolis.

Correspondence and reprints: Ronald P. Davis, M.D., Indiana University School of Medicine, Department of Ophthalmology, 702 Rotary Circle, Indianapolis, IN 46202.

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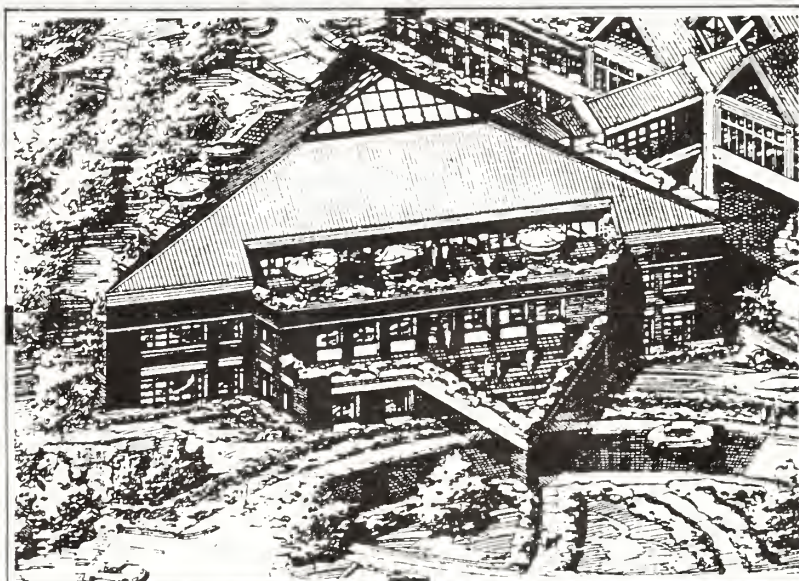
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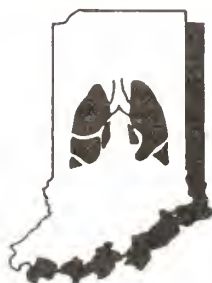
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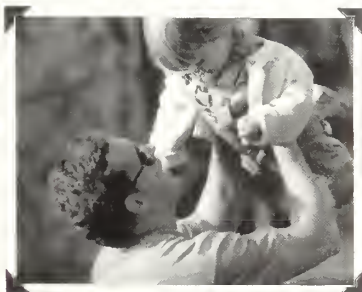
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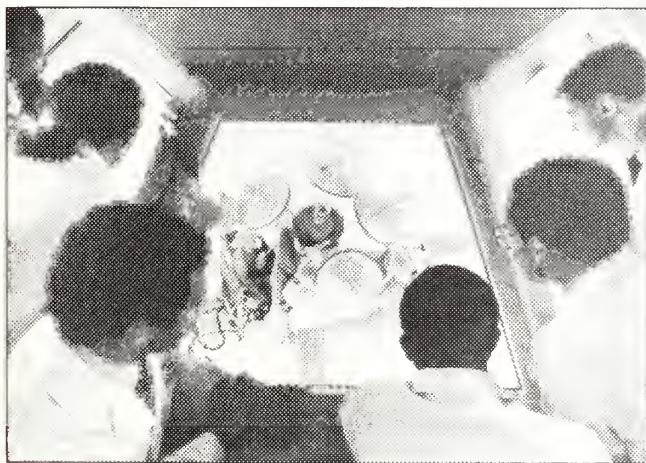
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■ alliance report

AMA Alliance House of Delegates report

Sue Ellen Greenlee, ISMA
Alliance president

During the AMA Alliance annual meeting in Chicago in June, Indiana received a Membership Award for organizing a new county alliance, LaPorte-LaPorte, in 1993.

AMA President Joseph T. Painter, M.D., thanked the alliance for its efforts in the legislative arena, domestic violence projects and the AMA-ERF. The AMA relies heavily on the alliance and greatly appreciates everything the alliance members do.

Barbara Tippins, AMA Alliance president for 1994-95, stated her goals for next year with a theme of "One Choice/One Voice." She said we need to promote unity, solidarity and shared vision among physicians' spouses. Domestic violence, membership recruiting and retention, designating March as Alliance Awareness Month and continuing work on health system reform will be ongoing goals.

Reminder: The ISMA Alliance annual convention will be Oct. 20 through 22 at the Westin Hotel in Indianapolis. In addition to ISMA Alliance business, highlights will include George Lukemeyer, M.D., presenting "Trends in Medical School Admissions"; Jimmy Ryser, Indiana recording artist; a panel discussion, "Family Violence: The Physicians' Response"; and Ann Flitcraft, M.D., medical director for Project SAFE. For more information, call Rosanna Iler at the ISMA, (317) 261-2060 or 1-800-257-4762. ■



Delegates to the AMA Alliance meeting in Chicago included: (front row, left to right) Lisa Brueggemann, Columbus; Darlene Haddawi, Bloomington; Valerie Gates, Valparaiso; and Cheryl Haslitt, Muncie. (Back row) Patty Lackey, Evansville; Shirley Becker, Evansville; Ann Wrenn, Bloomington; Sue Ellen Greenlee, Kendallville; Fran Foster, Fort Wayne; and Rosanna Iler, ISMA Alliance executive director.

A lasting impression

Cheryl Haslitt, ISMA Alliance recording secretary

From the time I registered at the AMA Alliance annual convention in Chicago, I was impressed with how professional and organized it was. There was a wealth of information about legislation, the AMA-ERF, health promotions and membership development.

I was assigned to attend the reference committee dealing with health issues, where there was discussion on resolutions on tobacco use, handguns and assault weapons, gambling and Gangsta rap. The business of the House of Delegates was interesting. I enjoyed the installation of officers and was proud to see Indiana's Ann Wrenn installed as field director.

The AMA convention was a positive learning experience for me. It was refreshing to see alliance leaders from every state who are so committed to and excited about the alliance.

It was a pleasure to represent Indiana at the national level, and the convention renewed my enthusiasm. We can all be proud of our alliance. ■

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■ cme calendar

St. Vincent Hospital

St. Vincent Hospital Vascular Center will hold the "Sixth Annual Austin L. Gardner, M.D., Innovations in Vascular Care Conference" Nov. 11 at the Holiday Inn North in Indianapolis.

For registration information, call Ann Cole at (317) 582-7142.

Midwest AIDS Training

Clinical Training Associates Inc., in association with the Midwest AIDS Training and Education Center, will sponsor four programs in a medical seminar series on "Managing HIV Infection in the Primary Care Setting." The courses are:

- Sept. 21** - 'Red Flags' in the Office.
- Oct. 19** - Evaluation and Management of Asymptomatic HIV Infection.
- Nov. 16** - An Approach to the Patient with Fever.
- Dec. 14** - Caring for the Patient with End-Stage Disease.

All courses will be held at the Signature Inn, I-65 south and Southport Road exit, in Indianapolis. For registration information, call Clinical Training Associates at (317) 631-5535.

Neurology Associates

Neurology Associates Inc., in association with Community Hospitals Indianapolis, will present "What's New in Neurology for Primary Care" Nov. 3 at Jonathan Byrd's Conference Center in Greenwood from 8 a.m. to 1 p.m.

For more information, call Susan Stonebraker at (317) 352-9255.

Laparoscopic Advances

A half-day seminar, titled "Laparoscopic Advances in General Surgery for the Primary Care Physician," will be presented Oct. 5 at the Twin Lakes Golf Club in Carmel. The course is sponsored by George Rowe, M.D., and Keith McEwen, M.D., both of Indianapolis.

For more information, call Maribeth Sellers, (317) 845-0060.

Reid Hospital

Reid Hospital & Health Care Services in Richmond will present "Arrhythmia Management for the 1990s" Sept. 22.

For registration information, call Marie Hopper at (317) 983-3112.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these CME courses:

- Oct. 6** - Annual Family Medicine Seminar - Primary Care Dermatology.
- Oct. 20** - Acceptable State of Depression.

Both courses will be in the hospital's amphitheatre. For registration information, call (812) 479-4468.

The Indiana Hand Center

The Indiana Hand Center in collaboration with St. Vincent Hospital will present "Treating Com-

mon Conditions of the Upper Extremity: A Proactive Approach for Primary Physicians" Sept. 21 at The Indiana Hand Center in Indianapolis.

For registration information, call Kevin Essington at (317) 471-4394.

Community Hospitals

Community Hospitals Indianapolis will present the "Fifth Annual Cardiovascular Symposium: Management Strategies for Primary Care Practitioners" Sept. 24 at the Embassy Suites in downtown Indianapolis.

For registration information, call Donna Grahn, (317) 355-5714.

American College of Cardiology

The American College of Cardiology will present "Advanced Echocardiography: Update 1994" Sept. 19 through 21 at the University Place Conference Center and Hotel in Indianapolis.

For more information, call the American College of Cardiology at 1-800-257-4739.

The Ear Institute

The Ear Institute of Indiana Inc. and Community Hospitals Indianapolis will present "Otology Update 1994" Sept. 21 at the Omni North Hotel in Indianapolis.

For more registration information, call (317) 842-4757 or 1-800-522-0734. □



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 7 – Girdhar Ahuja, Indianapolis (1996)
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 10 – John L. Swarner, Valparaiso (1994)
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 John D. MacDougall, Indianapolis (1995)
 Michael O. Mellinger, LaGrange (1995)
 John A. Knote, Lafayette (1994)
 Shirley Khalouf, Marion (1994)
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 Secy: Gerald Bowen, Lawrenceburg
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 Secy: Rahim Farid, Brazil
 Annual Meeting: May 25, 1995
 6 - Pres: Helen Steussy, New Castle
 Secy: to be announced
 Annual Meeting: May 10, 1995
 7 - Pres: Craig Moorman, Franklin
 Secy: John Schneider, Indianapolis

Annual Meeting: to be announced
 8 - Pres: Kathleen A. Galbraith, Portland
 Secy: Mark A. Haggenjos, Portland
 Annual Meeting: June 7, 1995
 9 - Pres: Herschell Servies, Lebanon
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 14, 1995
 10 - Pres: Frank Hieber, Munster
 Secy: Floyd Manley, Hammond
 Annual Meeting: April 29, 1995
 11 - Pres: William D. Dannacher, Wabash
 Secy: Jack Higgins, Kokomo
 Annual Meeting: Sept. 14, 1994
 12 - Pres: Joseph Manthey, Bluffton
 Secy: Brenda Stiles, Fort Wayne
 Annual Meeting: Sept. 15, 1994
 13 - Pres: Donald Smith, South Bend
 Secy: John W. Schurz, South Bend
 Annual Meeting: to be announced

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Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Hame Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Managed Health Plans and the corporate affiliate of Arnett Pharmacy.

Practice Setting

At this time, over 110 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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Lafayette, Indiana

■ obituaries

Charles J. Cooney, M.D.

Dr. Cooney, 92, a retired Fort Wayne urologist, died May 18, 1994, at St. Joseph Medical Center.

He was a 1927 graduate of the University of Iowa College of Medicine and an Army Air Force veteran of World War II.

Dr. Cooney, who had lived in Fort Wayne since 1934, was a urologist with Northeast Indiana Urology, retiring in 1988.

Phillip E. Hodonos, M.D.

Dr. Hodonos, 56, a Michigan City family practitioner, died June 23, 1994, at St. Anthony Hospital.

He was a 1963 graduate of the Indiana University School of Medicine.

Dr. Hodonos, who practiced at Michigan City's Medical Group, was president of the medical staff at St. Anthony Hospital and had been on the staff at Memorial Hospital. He was also president of the medical staff at the Open Door Health Clinic, which provides health services for those unable to get care elsewhere.

Robert S. McElroy, M.D.

Dr. McElroy, 89, a retired Princeton surgeon, died July 3, 1994, at his home.

He was a 1934 graduate of the Indiana University School of Medicine. During World War II, he headed a surgical team in the 97th Evacuation Hospital in Europe from June 1944 to October 1945.

Dr. McElroy practiced in

Princeton from 1935 to 1978 and had served as chief of staff at Gibson General Hospital. He was a member of the American Society of Abdominal Surgeons. He had served as chairman of the Farmer's National Bank board and was a member of the board of Haubstadt State Bank.

Richard J. Purcell, M.D.

Dr. Purcell, 70, a Griffith family practitioner, died June 6, 1994.

He was a 1949 graduate of the Loyola University Stritch School of Medicine and an Air Force veteran of World War II.

Dr. Purcell was a charter member and fellow of the American Academy of Family Physicians, a past president of the medical staff at St. Mary Medical Center in Lake County and a past chairman of the family practice department at St. Mary's.

George M. Reul, M.D.

Dr. Reul, 50, a Kokomo family practitioner, died May 11, 1994, at his home.

He was a 1969 graduate of the Indiana University School of Medicine.

Dr. Reul was affiliated with the Burlington Clinic, the St. Joseph Hospital and Health Center and Howard Community Hospital. He had served as chief of the medical staff and chief of the department of medicine at St. Joseph Hospital. Dr. Reul also served as physician for Northwestern School Corp. and Haynes Interna-

tional and was a medical director for Americana Nursing Home. He was a member of the American Academy of Family Physicians and the American Academy of Occupational Physicians.

Daniel C. Tweedall, M.D.

Dr. Tweedall, 81, a retired Evansville dermatologist, died July 5, 1994, at St. Mary's Medical Center.

He was a 1939 graduate of the St. Louis University School of Medicine and an Army Air Force veteran of World War II. He graduated from the Aviation School of Medicine in Randolph Field, Tex., and served as a flight surgeon.

Dr. Tweedall served on the staffs of Deaconess, St. Mary's and Welborn Baptist hospitals. He was a member of the American Academy of Dermatology, the American Geriatrics Society, the American Society of Contemporary Medicine and the American Society for Dermatologic Surgery. He had served as president of the Indiana State Dermatology Society.

Robert J. Yingling, M.D.

Dr. Yingling, 64, a retired radiologist formerly of Indianapolis, died July 4, 1994, in Clearwater, Fla.

He was a 1956 graduate of the University of Cincinnati College of Medicine and a Navy veteran.

Dr. Yingling, who retired in 1989, had been a radiologist in Indianapolis 27 years. □



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These bureaucrats may have good intentions. But they don't have the scientific knowledge and training to make such decisions. After all, most studied business. Not medicine.

That's why the 300,000 members of the American Medical Association (AMA) are working to make sure the final plan guarantees physicians will keep primary responsibility for setting the standards of medical care. So you and your doctor will be free to decide on the best course of treatment for you.

But we can't do it without your help. Call your legislators and let them know how you feel. And for more information about health system reform, write the AMA, Department 4142, 515 North State Street, Chicago, IL 60610 or call **800 348-3047**.

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■ news briefs

Genome research director to give Beering lecture

Frances S. Collings, M.D., Ph.D., director of the National Center for Human Genome Research at the National Institutes of Health, will deliver the 1994 Steven C. Beering Award Lecture at the Indiana University School of Medicine.

Dr. Collings will speak at 8:30 a.m. Oct. 12 at the University Place Conference Center Auditorium on the IUPUI campus.

Health reform could hurt medical technology

Health care reforms being considered by Congress could have serious long-term consequences for the quality of medical care available to American consumers. This was one of the findings of a report titled "Health Care Reform, Regulation and Innovation in the Medical Device Industry" issued by the Competitiveness Center of Hudson Institute, which is headquartered in Indianapolis.

The report identifies problems with the following four changes under consideration in the health system reform debate:

- A uniform benefits package required by a national administrative board would weaken innovation by specifying the mix of technologies reimbursable in the health care system. Competing technologies could be shut out of the market, frustrating innovation and clinical testing of new technologies.
- Price controls would threaten innovation because firms would be less capable of recovering the costs of research and development, by being coerced into selling their product at artificially low prices.

- Micromanaging and reducing funding for medical education programs will reduce the pool of specialists and research centers that create, test and distribute medical devices.
- Inhibiting the acquisition of new equipment by medical providers would seriously threaten the viability of industry's sales and could potentially deny Americans access to the latest health care technologies.

The report also said that America's tradition of cutting-edge medical technology is already facing severe threats, including the following:

- A serious regulatory slowdown in the approval of medical devices at the U.S. Food and Drug Administration. The approval process has become so slow that many small firms no longer have the financial ability to stay in business while their products await approval.
- Product liability suits threaten innovation as manufacturers and suppliers face the potential of multi-billion dollar settlements, making the development of revolutionary devices less attractive.

Reforms recommended in the report include:

- The FDA must radically alter its regulatory efforts and reconfigure its method of rewarding analysts and of allocating resources.
- Product liability reform is needed. Reforms should base liability on fault, increase the role of arbitration, improve the quality of scientific evidence and give greater weight to FDA approval in liability suits.

- The information available to the market through health technology assessment needs to be improved to help guide providers and consumers in making medically sound and cost-effective treatment decisions.
- Both public and private payers should grant provisional coverage for very expensive or controversial new technologies approved by the FDA and let the cost-effectiveness be tested in the marketplace.
- Providers should "bundle" payment of medical procedures into categories that are at least as broad as current diagnosis related groups. This would motivate physicians to use the most cost-efficient technologies and spur development of new cost-saving technologies.

The Hudson Institute is a private, not-for-profit public policy research organization, founded in 1961.

Orthopaedic groups form new alliance

The physicians of The Indiana Hand Center in Indianapolis and Orthopaedics Indianapolis have formed Specialty Physician Alliance Network, LLC, a joint venture. The new alliance initially unites 35 physicians with 10 hospital affiliations.

The Indiana Hand Center, founded in 1972, specializes in the treatment and rehabilitation of the hand, wrist, elbow and shoulder. Orthopaedics Indianapolis, founded in 1962, is the largest orthopaedic practice in Indiana, with 23 physicians.

By sharing resources and facilities, the Specialty Physician Alliance Network expects to be

better able to control costs.

ISMA president-elect chosen director of PICI board

William E. Cooper, M.D., ISMA president-elect, is one of three people recently elected to initial terms of office as directors of Physicians Insurance Company of Indiana. Also elected are George A. Buskirk Jr. and R. Denny Currier.

Dr. Cooper, a Columbus otolaryngologist, has served the ISMA as chairman of the board and speaker of the House of Delegates. He is a fellow of the American College of Surgeons and has served as president of the Indiana Academy of Otolaryngology/Head and Neck Surgery.

Buskirk is senior vice president and trust officer of Union Federal Savings Bank in Indianapolis and a director of the Indianapolis Bar Association. Currier is administrator of the Welborn Clinic in Evansville and a member of the board of directors of Maxicare of Indiana.

Resources available on Huntington's disease

The Huntington's Disease Society of America, Indiana Chapter, has listed several resources available to help physicians in the diagnosis and management of the disease.

The following information is excerpted from a Progress Report, Research Roster for Huntington's Disease, by P. Michael Conneally, Ph.D., of the Medical and Molecular Genetics Department at the Indiana University School of Medicine.

"Huntington's disease (HD), an autosomal dominant disorder, is characterized by the appearance of progressive involuntary move-

ments (chorea) and dementia, usually in adult life. The major pathological features of HD are a primary loss of cells in the caudate nucleus and putamen and a decrease in the level of neurotransmitter and associated enzymes, as well as abnormalities in some receptor sites. Presenting symptoms commonly include depression, forgetfulness, personality change, restlessness, clumsiness, altered speech and handwriting, affective disorders and even psychotic behavior. Chorea is generally considered the 'definitive' sign of the disorder, although psychological and behavioral changes have been noted to occur a decade or more before these movements appear. As the disease progresses, all of the symptoms worsen. Choreic movements and mental impairment usually become quite severe.

"While the average age of onset is approximately 38 years, it has been known to appear as early as age 2 and as late as age 75. Symptoms of the disease can vary greatly from one individual to the next, with age of onset being an important variable. Children tend to have a rapidly progressing, 'rigid' form of the disease with a duration somewhat less than 12 years. Individuals with an onset of symptoms in middle-adult life typically have a more gradual deterioration with a disease duration of approximately 18 years. Although the onset of symptoms and rate of progression may vary, the prognosis is always one of relentless deterioration. Martin (*Nature*, 229:205-206, 1982) has aptly described the disease as 'genetically programmed cell death in the human central nervous system.' Since the mode of inheritance is autosomal domi-

nant, both sexes inherit the disease with equal frequency, and 'at-risk' offspring of an affected individual have a 50% chance of inheriting the disease. The summary report of the Commission for the Control of Huntington's Disease and its consequence states, 'Huntington's disease is a family disease. Every member of the family is affected - emotionally, physically, socially - whether patient, at-risk or spouse. And the disease occurs not once, but over and over again in successive generations (Report: Commission for the Control of Huntington's Disease and Its Consequences, Volume 1 - Overview, Maryland: U.S. Dept. of Health, Education and Welfare, Public Health Service and National Institutes of Health, 1977, p. xix).'"

The Huntington's Disease Society also recommends these other resources for physicians:

- *A Physician's Guide to the Management of Huntington's Disease: Pharmacologic and Non-Pharmacologic Interventions.* Neal G. Ranen, M.D.; Carol E. Peyser, M.D.; Susan E. Folstein, M.D., HDSA, New York, July 1993. 1-800-345-HDSA.
- Indiana University School of Medicine, Department of Molecular and Medical Genetics: Confirmatory diagnostic clinic or research roster, (317) 274-5744; pre-symptomatic, prenatal and genetic testing, (317) 274-2390.
- HDSA, Indiana Chapter, Information Line, (317) 271-0624.
- HDSA, National Chapter, Information Line, 1-800-345-HDSA. □

■ people



Dr. Morrison

Dr. Andrew L. Morrison, an Indianapolis psychiatrist, has been honored by two groups. He received the 1994 National

Alliance for the Mentally Ill (NAMI) Exemplary Psychiatrist Award for providing superior care for people who have severe mental illnesses in central Indiana. NAMI is a grassroots family self-help, support and advocacy organization dedicated to improving the lives of people with severe, biologically based brain diseases. Dr. Morrison also received the Normal Skole Service Award from the Mental Health Association in Marion County. The Skole Award honors Normal Skole, the association's executive director from 1958 to 1991, and is given to a person or group who has demonstrated unique and exceptional service to improve the quality of life for people with mental illness or emotional distress. Dr. Morrison has served as the association's media spokesperson for its involvement in the National Public Education Campaign on Clinical Depression.

Dr. Rama Jager, a colon and rectal surgeon in Indianapolis, received the Ray Sears Memorial Award from Indiana Sen. Richard Lugar. He was recognized for the colorectal cancer awareness campaign



Dr. Jager

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

May

Broadie, Thomas A., Indianapolis
Cline, Donald L., Indianapolis
Cua, Rosita Lee S., Indianapolis
Dion, Francoise M., Granger
Duprat, Gerard, Granger
Eller, Alvan L., Flora
Gartner, Joseph C., Jasper
Jones, Rhys Davies, Carmel
Molstad, Clay L., Lafayette
O'Brien Plascak, Marianne, Rensselaer
Osos, Nancy A., Fort Wayne
Reihman, Dana H., Richmond
Roth, Bertram S., Indianapolis
Rouhana, Rodolph, Indianapolis
Speckman, Glenn H., Indianapolis
Stewart, John C., Kokomo
Swaim, J. Franklin, Rockville
Tran, Lau, Lyons
Volan, George J., Merrillville
Webb, Bob L., Odon
Wells, William R., Princeton

June

Allen, Deborah I., Indianapolis
Bowman, John A., Kokomo
Chua, Gonzalo T., Carmel
Coats, Charles W., Greenwood
Cronen, Paul W., Madison
Dahling, Fred W., New Haven
Dye, William E., Oakland City
Echsner, Herman J., Columbus
Ellis, Robert F., Merrillville
Henley, Anne E., Kokomo
Hirons, W. Timothy, Richmond
Horner, Terry G., Indianapolis
Langley, Beryl W., Jeffersonville
O'Yek, Victorio, Schererville
Pandya, Renu R., Lafayette
Schmetzer, Alan D., Indianapolis
Serwatka, James A., South Bend
Sneary, Max E., Avilla
Solotkin, David, Indianapolis
Stephens, James E., Brazil
Thompson, John M., South Bend
Tritch, Dan L., Fort Wayne
Ungemach, Willo F., Fort Wayne
Weeks, Michael B., Carmel

he conducts each March by distributing thousands of free hemocult cancer-testing kits. He also presents seminars to community and school groups. The award, which honors a friend of Lugar's who was committed to physical fitness and health, is given to those who exemplify the phrase "Good Health and Good Living."

Dr. William Beeson, an Indianapolis facial plastic surgeon, and **Dr. C. William Hanke**, a dermatologist at the Indiana University

Medical Center, were course directors for the Dermatology and Facial Plastic CO₂ Laser Surgery Workshop in Indianapolis. The course attracted physicians from as far away as Korea, Germany and Brazil. Dr. Beeson was one of the authors of an article titled "Carbon Dioxide Laser Blepharoplasty, a Comparison to Electrosurgery" that appeared in the June issue of the *International Journal of Aesthetic and Restorative Surgery*.

Dr. Richard D. Zeph, a

Carmel facial plastic surgeon, discussed chemical peels on "The Morning Show" on Channel 27 in Indianapolis.

Dr. George Underwood, a Lafayette family practitioner, received the National Federation of Interscholastic Coaches Association's distinguished service award, given for unselfish devotion to interscholastic athletics. Dr. Underwood, the chairman of the ISMA sports medicine commission, has been the team physician for Lafayette Jeff for 26 years.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, lectured and instructed colleagues in Morelia, Mexico. He discussed rhinoplasty, blepharoplasty, face lifts and chin implants and performed eight surgeries.

Dr. Hill Hastings II, an Indianapolis hand surgeon, represented the United States as the foreign liaison and program chairman for the combined meeting of the Hellenic and American Societies for Surgery of the Hand held in Athens and Corfu, Greece. He gave lectures on "Endoscopic Carpal Tunnel Release: Rationale, Techniques and Results," "Limited Open Carpal Tunnel Release," "Decision Making, Classifications, Combined Injuries of the Hand," "Zone I and II Flexor Tendon Laceration with a Four-Strand Repair and Early Active ROM" and "Flexor Tendon Repair Zone II."

Dr. Thierry Wilbrandt, an Indianapolis ophthalmologist, was an instructor at the radial keratotomy beginner and update course hosted by Chiron; courses were held in St. Louis, Fort Lauderdale, San Francisco and Chicago. He presented a paper on "Pearls from the System," which

deals with enhancement strategies in radial keratotomy, at the American Society of Cataract and Refractive Surgery meeting in Boston. Dr. Wilbrandt has published the paper in book form, which is available for sale from his office, (317) 247-1335.

Dr. Steven F. Isenberg, an Indianapolis otorhinolaryngologist, has had a paper accepted for publication by *Otolaryngology - Head and Neck Surgery*. The title of the paper is "Thyroid Abscess Resulting from Fine Needle Aspiration Biopsy."

Activities of physicians at Nasser, Smith & Pinkerton of Indianapolis include the following: **Dr. John Slack** spoke on "Physicians' Perspective on Hospitals' Needs" at the "Cardiology in the '90s" seminar in Washington, D.C., and gave a talk on quality management at the Indiana Medical Review Board meeting at Indiana State University. **Drs. Borys Surawicz** and **Bruce Waller** are members of the editorial board of *Cardiology in the Elderly*, a new journal.

Accomplishments and activities of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Daniel Gelfman** was appointed clinical assistant professor of medicine at the Indiana University School of Medicine and is serving on the board of directors for the Madison County Heart Association. **Dr. Eric Prystowsky** co-authored *Cardiac Arrhythmias*, published by McGraw-Hill, and served as co-chairman of the "ECG Diagnosis of Arrhythmias" symposium sponsored by the American Heart Association in Dallas. **Drs. Morton Tavel**, **Joe Noble** and **Ronald Landin** jointly authored the "Heart" chapter in the text-

book *Laboratory Medicine*. **Dr. Thomas Linnemeier** spoke on "Treatment of Chronic Coronary Artery Disease at St. Vincent Hospital in Indianapolis" during the Brazilian Hemodynamic Congress in Sao Paulo, Brazil. **Dr. Ronald Landin** was named adjunct professor of physiology and health science at Ball State University through the 1995-96 academic year.

Dr. Gregory Rowdon has joined the staff of Methodist Sports Medicine Center in Indianapolis. He is a team physician for Arlington High School, Hanover College, Vincennes University and Indiana State University.

Dr. Michael A. Williams, a former president of the ISMA Resident Medical Society, has been elected to the American Medical Association's Council on Scientific Affairs. He is now a neuro-intensivist at Johns Hopkins University in Baltimore.

Dr. John T. Hinton of Cincinnati was re-elected to a second term on the board of the Federation of State Medical Boards.

Dr. Luciano P. Musngi of Pendleton retired in May.

Dr. Jerry Jamison, a Clarksville internist, was inducted as a fellow of the American College of Physicians.

Dr. John D. Ayres, director of risk management at Wishard Memorial Hospital, was elected president of the Indiana University Medical School Alumni Association.

Dr. Allen S. Martin has retired after 30 years of practice in the Shipshewana area. He will continue to do some consulting and assist with surgeries.

Dr. David Spalding, a Mishawaka family practitioner,

has joined St. Joseph Mishawaka Health Services as vice president of medical affairs.

Dr. Peter A. Rosario, an Evansville pulmonary diseases specialist, was named vice-president of the American Lung Association of Southwest Indiana.

Dr. Olaf B. Johansen has accepted a three-year appointment as cancer liaison physician at Kendrick Memorial Hospital in Mooresville.

Dr. Jeffrey F. Granger, a Logansport orthopaedic surgeon, has passed the Federal Aviation Administration basic aviation medical examiner course.

Dr. John H. Mahon of South Bend was named a fellow of the American Society for Surgery of the Hand.

Dr. Owen H. Lucas Jr., a Chesterton family practitioner, recently became qualified as a certified medical review officer.

Dr. Nancy A. Osos, a Fort Wayne family practitioner, was elected to the board of directors of Lutheran Hospital of Indiana.

LaPorte Hospital recently honored the following physicians: **Dr. Edwin C. Mueller**, a surgeon, received the R.B. Jones, M.D., Award for Community Service. **Dr. Hester J.E. Muller**, a radiologist, received the G.O. Larson, M.D., Award for Professional Leadership and Achievement. Also honored were retiring physicians **Dr. George P. Backer**, a radiologist, and **Dr. Jose Sanchez**, an anesthesiologist.

Dr. Michael E. Seidle, medical director at the Ball State University student health center, was appointed to the National Services Advisory Council of the National Multiple Sclerosis Society.

Dr. Charles Baran, medical director of the pain rehabilitation

IAFP installs president, presents awards

The Indiana Academy of Family Physicians installed new officers and presented several awards at its annual meeting at French Lick Springs Resort.

Dr. Bruce E. Burton of Corydon was installed as president. A graduate of the University of Texas Southwestern Medical School, he is a diplomate of the American Board of Family Practice.

Dr. Marvin E. Priddy of Fort Wayne was named the Physician of the Year. He has practiced in a multi-specialty group for more than 21 years and serves as the associate director of the family practice residency program in Fort Wayne. He has been the team physician for North Side High School since 1958.

Dr. Teresa A. Beckman of Evansville received the Distinguished Public Service Award for her volunteer work. She helped establish the ECHO (Evansville Coalition for the Homeless) Health Center, which opened in 1990, and serves as its medical director and as a board member.

Dr. Richard D. Feldman, clinical director of the family practice residency program at St. Francis Hospital in Beech Grove, received the A. Alan Fischer Award. Dr. Feldman has directed the program since 1981 and also serves on the Indiana Medical Education Board. The award is given for outstanding contributions to family practice education.

Dr. Charles W. Hachmeister of Evansville received the Lester D. Bibler Award, which recognizes long-term dedication and leadership toward furthering the development of family medicine. Since joining the IAFP in 1971, he has held several positions, including president, and served on many committees and commissions. He is a part-time associate director of the Deaconess Hospital family practice residency program. □

center at St. Joseph's Medical Center in South Bend, was named a fellow of the American College of Pain Medicine.

Dr. Paul Siebenmorgen, a Terre Haute family practitioner, received the distinguished alumnus award from the Indiana University School of Medicine. The school has given only 33 such awards in its 90-year history.

Dr. Robert P. Inlow of Shelbyville was installed as president of the Indiana Chapter of the American College of Surgeons.

Dr. Deborah Stoner, an Evansville family practitioner, received the American Medical Association/Burroughs Wellcome Co. Leadership Award for outstanding leadership in community service. She was recognized for her work with the National Council of Family Practice Residents, Vanderburgh County Medical Society and Medical Alliance Health Fair, United Way fundraising drive, Indian Health Service and for her presentations to schoolchildren about the health

risks of tobacco use.

Dr. Edward L. C. Broomes of East Chicago was honored at a reception and awards dinner sponsored by the Guyanese and International Friends of Dr. Broome Committee. He is known as the city's longest-practicing doctor, was the first African-American doctor in the area to gain patient-admitting privileges at a hospital and has won many professional and civic awards.

New ISMA members

Keith B. Allen, M.D., Indianapolis, thoracic surgery.

Joe M. Anderson, D.O., Wabash, internal medicine.

Robert P. Anderson, D.O., Merrillville, general surgery.

Neela R. Bakane, M.D., Muncie, family practice.

Daniel T. Barrido Jr., M.D., Marion, gastroenterology.

Frank J. Bender III, M.D., Fort Wayne, physical medicine and rehabilitation.

Reeta Bhargava, M.D., Indianapolis, family practice.

Prakash S. Bhoopalani, M.D., Muncie, pediatrics.

Linda L. Block, M.D., Indianapolis, family practice.

Roy E. Cecchi, M.D., Huntingburg, obstetrics and gynecology.

Kevin C. Chang, M.D., Indianapolis, ophthalmology.

Harin J. Chhativala, M.D., Fort Wayne, internal medicine.

Archie C. Collins, D.O., Lyons, general practice.

Richard L. Dobben, M.D., Michigan City, radiology.

David E. Dollens, M.D., Seymour, internal medicine.

Sandra L. Gadson, M.D., Gary, internal medicine.

Brett A. Graham, M.D., Brownsburg, family practice.

David A. Heimansohn, M.D., Indianapolis, general surgery.

Joseph M. Henderson, M.D., Indianapolis, gastroenterology.

Kristine A. Hess, M.D., Marion, dermatology.

Carla R. Hightower, M.D., Highland, anesthesiology.

James R. Ingram, D.O., Washington, orthopaedic surgery.

Jon J. Jansen, M.D., Indianapolis, general surgery.

Noel L. Jansen, M.D., Indianapolis, internal medicine.

Greg R. Johnson, D.O., Fort Wayne, internal medicine.

Chad C. Lamb, M.D., Anderson, family practice.

Albert C. Lee, M.D., Indianapolis, neurology.

Eldred H. MacDonell Jr., M.D., Indianapolis, internal medicine.

Brian L. Miles, M.D., Indianapolis, family practice.

Janet L. Minella, M.D., Clarksville, pediatrics.

Charles Mok, D.O., Elkhart, emergency medicine.

Cheryl L. Morgan-Ihrig, M.D., Highland, internal medicine.

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Linda L. Neuman, M.D., Carmel, internal medicine.

Theodore A. Nukes, M.D., Indianapolis, neurology.

Maria C. Paillaman-Bello, M.D., Evansville, internal medicine.

Troy D. Payner, M.D., Indianapolis, neurological surgery.

Julian A. Procope, M.D., Indianapolis, ophthalmology.

Daniel R. Shirley, M.D., Evansville, oncology.

David M. Simon, M.D., Munster, internal medicine.

Michael E. Smothers, M.D., Anderson, family practice.

Bruce A. Sobko, M.D., Merrillville, anesthesiology.

Gary D. Thompson, M.D., Indianapolis, family practice.

Robert D. Timmerman, M.D., Indianapolis, radiation oncology.

Terry A. Vaughan, M.D., Indianapolis, psychiatry.

John M. Walker, M.D., Indianapolis, family practice.

Judson B. Wood, M.D., Gary, orthopaedic surgery. □

What's on your plate?

What does your personalized license plate reveal about you? Personalized plates often provide a clue to a physician's specialty, hobby or leisure time interests.

INDIANA MEDICINE thought it would be fun – and a reprieve from talk of health system reform – to find out what your colleagues are spelling out on their so-called "vanity plates." We'll tell you what we learn in a story in an upcoming issue.

But we need your help. If you or a physician you know has a personalized license plate, please write or fax the information to us by Nov. 1. Please include the physician's name, address, telephone number, specialty and the wording on the personalized plate. Information should be mailed to Tina Sims, Managing Editor, Indiana Medicine, 322 Canal Walk, Indianapolis, IN 46202, or faxed to the ISMA at (317) 261-2076. □

■ classifieds

NORTHEAST INDIANA – Board-eligible physician needed part-time for walk-in/industrial clinic. For more information, please call Jill Treesh at (219) 925-9511 or submit CV to AMIC, 500 S. Grandstaff Dr., Suite G, Auburn, IN 46706.

IMMEDIATE OPENING for BC/BE family practitioner with ER experience to staff hospital-based, fast track/express care center located within St. Vincent Hospital ED, Indianapolis. Full benefits, including occurrence malpractice, health and disability insurance, fees and dues paid, paid vacation, CME allowance and participation in pension plan, are offered. Please send CV to Dr. Susan Stephens, 11011 Ditch Road, Carmel, IN 46032, (317) 844-9640.

DOCTOR'S OFFICE CLOSING – For sale: Haworth front office modular work stations and chairs (4). GTE Executech office phone system. New Med 7000: Vascular recorder. Medasonics BF4A Vascular Doppler (hand-held). 2 oak credenza files. Open lateral chart file (metal). Desk. BP cuffs. Wheelchair. Transcription system. Beeper. 2 refrigerators. 2 microwaves. Miscellaneous supplies and furniture. Contact R.T. Rolley, M.D., 610 Ridgewood Dr., West Lafayette, IN 47906, (317) 463-7675.

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FAMILY PRACTICE – BLOOMINGTON/ELLETTSVILLE AND BROWNSTOWN. Outstanding opportunity for BE/BC family practitioners to join FP/EM/urgent care group and practice traditional family practice in one of two small group settings. OB optional. Very competitive salary, generous benefits, the potential for productivity bonuses and the security of a statewide group with a 23-year history. Contact Jim Gardner, M.D., ECP Healthcare, 640 S. Walker St., Bloomington, IN 47403, (812) 333-2731.

OUTPATIENT CLINIC: Board-certified physician needed to work with Fort Wayne, Indiana's leading four-clinic corporation. \$200,000 salary package possible, depending upon experience and hours worked. Flexible schedule; no call coverage. Call HR director at (219) 489-2772, ext. 411, for more details or fax CV to (219) 489-9851. We'll do the billing and administrative work ... you practice medicine!

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NW INDIANA – Private practice. No OB. 1:8 call. \$105K first year. Near Chicago. For more information, contact Patience Schock, 1-800-765-3055, 222 S. Central, Suite 700, St. Louis, MO 63105, fax (314) 726-3009.

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Advertising index

American Medical Association	399
Arnett Clinic	431
Auto Purchasing Unlimited	442
Bethesda Group Practice	425
Central Pharmaceuticals	341
Custom Creations	427
Fifth Third Bank	351
ISMA Insurance Agency	345, Covers
Medical Protective	363
Midwest Medical Management	427
National Institute for the Clinical Application of Behavioral Medicine	350
Palisades Pharmaceuticals	340
Physicians' Directory	410
Physicians Insurance Co. of Indiana	Cover
Reeves Hummer	429
The Money Store	343
U.S. Army	425
University Place	369
Zeigler Carter Cohen & Koch	442

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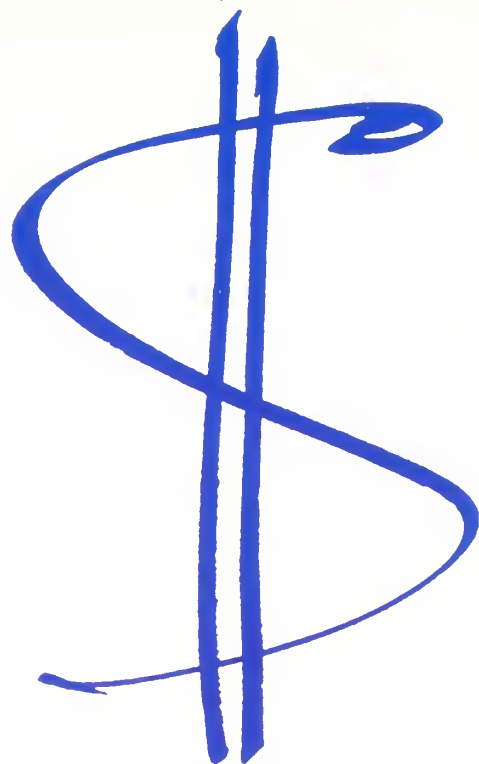
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500	<ul style="list-style-type: none"> \$500 calendar year deductible, \$1,000 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		
1,000	<ul style="list-style-type: none"> \$1,000 calendar year deductible, \$2,000 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		
2,000	<ul style="list-style-type: none"> \$2,000 calendar year deductible, \$6,000 per family Stop-Loss limit \$10,000 per person, \$30,000 per family 	✓	✓		
250PPN	<ul style="list-style-type: none"> \$250 calendar year deductible, \$500 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓	✓	✓
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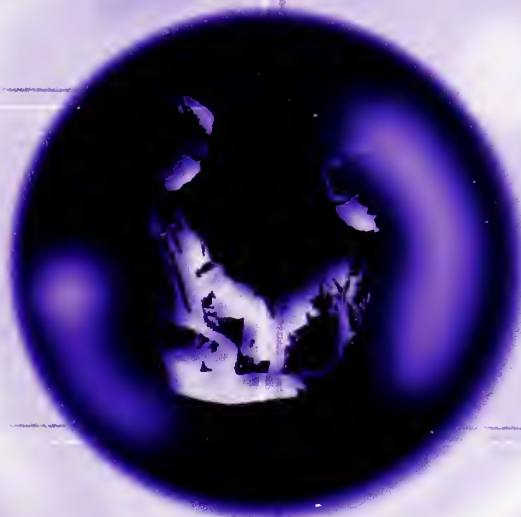
INDIANA MEDICINE

The Journal of the Indiana State Medical Association

November/December 1994

Vol. 87, No. 6

Peer review shifts focus to patterns of care



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features

Licensing board's duty: To protect the public 452
INDIANA MEDICINE interviews N. Stacy Lankford, M.D., president of the Medical Licensing Board of Indiana, about the problems that bring physicians before the board and what sanctions the board can impose.

Peer review shifts focus to patterns of care 458
Peer review organizations are taking a new direction. In a move most doctors will welcome, PROs are focusing on patterns of care instead of on individual case review.

The new frontier for physicians: Revenue-focused 462
Physicians who want to succeed in the era of managed care are advised to concentrate on increasing revenue, not on reducing expenses.

The death of Wolfgang Amadeus Mozart 464
Many biographers still speculate about the illness that claimed the life of Mozart in 1791. An Evansville physician summarizes the diagnostic possibilities.

How to settle a dispute without going to court 468
Alternative dispute resolution allows physicians to resolve disagreements in settings other than the traditional legal system.

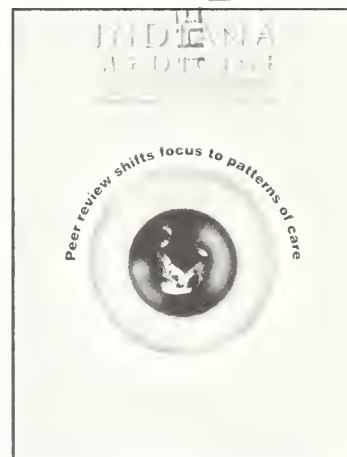
Tax planning for college 470
The Annual Gift Tax Exclusion gives physicians an alternative to home equity loans for financing their children's college education.

Index to INDIANA MEDICINE, volume 87 472

scientific contributions

Intraoperative brain mapping during
tumor resection from critical areas of the brain 476

Maternal mortality in Indiana: A report
of maternal deaths in 1992 480



Cover story begins on page 458. Cover design by Greg Albright, owner of Influx Design Communications.

departments

stethoscope 446
letter to editor 448
commentary 450
drug names 463
alliance report 498
statement of ownership,
management
& circulation 499
from the museum 500
cme calendar 502
news briefs 504
obituaries 506
people 508
classifieds 512

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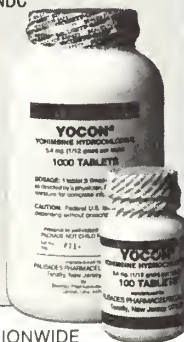
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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To help physicians find answers to their legal and financial questions, the Indiana State Medical Association has created the Physician Organizational Management Consulting (POMC) program. The program was established in response to physicians' changing needs and their desire to continue to provide high-quality care in the era of health system reform.

The POMC program refers physicians in need to consultants in the legal and financial fields. Consulting firms in the program include: Blue & Co. and Heaton & Eadie, accountants and health care consultants, and Hall, Render, Killian, Heath & Lyman and Krieg, DeVault, Alexander & Capehart, law firms. The firms have years of experience working with Indiana physicians in the health care industry and are well-versed in Indiana finance and health care law and consult on various medical practice issues.

To participate in the program, call Tim Brent, the ISMA's POMC representative, at (317) 261-2060 or 1-800-257-4762. The initial telephone calls to the ISMA and the participating consulting firm are free to ISMA members. If the problem you face demands more time than one phone call, you have the ability to retain the consultant to assist you in developing the right solution. As an ISMA member, you are guaranteed the best rates these consulting firms offer.

Physicians invited to Medicine Day and legislative reception

ISMA Key Contact physicians will have the opportunity to meet with their state legislators to discuss issues of concern during the ISMA's fourth annual Medicine Day, Jan. 25 at the Hyatt Regency Hotel in downtown Indianapolis. Key Contact physicians are encouraged to attend Medicine Day and show their appreciation to legislators for their efforts and help explain important issues to legislators.

Medicine Day includes a breakfast briefing on legislative issues, a visit to the Statehouse to meet with legislators and a luncheon to which all legislators are invited. The day will conclude with the ISMA/IMPAC Legislative Reception from 6 p.m. to 8:30 p.m. at the Hyatt Regency. The reception features a "Beach Party" theme.

For more information about Medicine Day, call Debbie Warner at the ISMA, (317) 261-2060 or 1-800-257-4762. Invitations to the reception will be mailed in December. Those who do not receive an invitation but would like to attend should call Susan Grant at the ISMA.

ISMA Key Contact program looks for more participants

The ISMA Key Contact program is looking for new members to help communicate with Indiana's congressional and state delegation. The program is a telephone tree to help make communication between physicians and legislators an easy and comfortable experience.

Participants in the Key Contact program receive legislative alerts and additional information and agree to contact legislators regarding proposed bills. To join the program, call Debbie Warner at the ISMA. □

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■ letter to editor

Steve Moses
Indianapolis

Liberals scream about the "health care crisis" and a desperately needed "health care reform." They throw out statistics like "37 million uninsured." They would like us to believe that American medicine is some gigantic, greedy beast that needs to be tamed so that everyone will have wonderful health. The truth is that there is no "health care crisis." Today doctors, nurses and medical staff are more knowledgeable, skilled and technologically advanced than those who worked 30 years ago, maybe 15 years ago. Yet, paradoxically, American health in general is deplorable. Politicians blame this condition on the medical and insurance industries, citing problems such as "access to care," "physician disbursement" and "insurance coverage." These changes could certainly improve the medical system. But the real problem is American health, not American health care.

Americans and the American lifestyle have become critically unhealthy. We eat too much, smoke too much and too often, and drink too much. We don't exercise enough (if ever), we take foolish risks (driving without seat belts) and participate in foolish activities (bungee jumping). We kill, rape, attack and injure one another with incomprehensible frequency. We continue to have dangerous sex and spread HIV, hepatitis and the whole gang of other diseases. And as if this wasn't enough, we glorify all of this behavior in the media, whether through Hollywood or the newspaper. And the irony is

that some expect the health care system to provide them with good health (often instantaneously). Notice the word "provide." Health care professionals are now "providers." What absolute garbage! Health care should begin with the individual, not be "provided" by doctors. Sadly, in this country the reverse appears to be true and this is precisely why we have a problem. Individuals don't take care of themselves. They wait until their health problems are unmanageable before coming in for professional help. America doesn't have a "health care crisis," it has a "health crisis."

Personal responsibility doesn't seem to exist anymore. Now we have lawsuits being filed to place special seating in cinemas for obese individuals. Guess who will foot that bill? Guess who pays for all of America's unhealthy activities? We do. Every year we collectively pay billions. Is this fair? Is it logical or just for a person to expend energy staying in shape, exercising regularly, eating right, quitting or refraining from smoking only to subsidize special accommodations at theaters? Choosing to be unhealthy is certainly an option open to everyone. But it is unnatural and illogical that others must financially support that individual's decision. Notice how this situation differs from the theoretical mechanism of health insurance.

The nature of insurance is for those who are healthy to subsidize those who are not. In return, the healthy ones have comfort knowing that if they should ever become unhealthy they will be financially prepared. It is not a faulty concept, but it was designed to run with a healthy majority. When that

majority dwindles or when the unhealthy outnumber the healthy, the concept breaks down. A healthy few cannot support the unhealthy many for long. This is the true "crisis." This is why health care costs have skyrocketed. Insurance and access to professional care are irrelevant if people do not begin to take care of themselves. Insurance does not equal better health.

The "health care crisis" was created more for political rather than medical reasons. Most American health care is superb, while American health is not. It is true that changes in physician disbursement, malpractice law and insurance coverage options could have a dramatic effect. But it is all secondary to the responsibility and decision of the individual. In fact, it might be argued that increasing coverage reduces incentives to stay healthy because the individual can become even less responsible for himself.

When President Clinton and his wife promised health care and held up a health credit card as a symbol of goodies to come, it was sheer idiocy. It was political. Neither one of the Clintons had the slightest clue about the problem or the solution. The best Clinton could have done would have been to motivate and inspire Americans to become responsible for themselves. Instead, he promised to provide for them, thus destroying and enslaving all personal aspiration, motivation and responsibility. □

The author, an Indianapolis resident, is a second-year student at the Indiana University School of Medicine.

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The dying man, the young physician and health reform

Barney Maynard, M.D.
Evansville

"Have a nice day, doc." He was dying, that was certain. Every day, at the end of the visit, he would cheerfully say the same thing to the young physician fresh into private practice. "Have a nice day, doc." How the young physician had come to loathe these daily visits, so futile and so predictable. But the dying man would not die quickly. Day after day (back then it was permissible to stay in the hospital to die,) it was always the same, "Have a nice day, doc."

His tragic story was so familiar. Far before retirement age, a rectal cancer, followed by major surgery; recurrence and radiation therapy; recurrence and chemotherapy; and recurrence. With the last recurrence, both kidneys were blocked, and he was in renal failure. At that terminal point, the young physician first met the dying man. The young physician was well schooled. Long before outcomes and parameters were to become the "keys" to medical practice, the young physician already knew the outcome and knew that the parameters for the dying man should dictate a quick, dignified and painless death without further suffering or intervention. But the young physician's conscience and ethical view of his profession mandated he include the patient in medical decisions. No matter, the young physician knew that the dying man would make the proper decision and fit within the parameters.

It was a confused and angry young physician who listened to the dying man say he wanted his kidney function back. Yes, he

knew that his cancer would continue to eat away at him, but this did not seem to bother the dying man. The young physician was outraged that the dying man was making such a poor decision. He was not fitting into the parameters of what should be done. However the young physician could do nothing now but abide by the dying man's decision. The surgery was done, a tube was placed in a kidney, and death from kidney failure was averted. The dying man did well from his surgery and promptly disappeared for three months. "Have a nice day, doc."

Now he was back and at the end of his disease. The young physician had little to offer as the malignant beast within the dying man slowly digested him from inside out. Each day the same. The young physician would ask the dying man if he wanted anything, but the dying man asked only for the comfort of pain medication. And always – always – the same good-bye, "Have a nice day, doc."

Late one evening, near the end of the dying man's suffering, a smile creased his lips when the young physician made his daily inquiry. "Do you think I could have a cold beer?" the dying man asked. A quick trip to a local liquor store and within a few minutes the young physician was sitting at the dying man's bedside sharing a beer with him. And then the dying man began to teach.

The dying man told the young physician how much he appreciated those three months he had been given. He told of his long and happy marriage and how the time the young physician had given allowed him to say good-bye in just the right way. He had been able to put affairs in order and to

say to friends and family what they had meant to him. He told of his trip to Florida to see a daughter and grandchildren. How much it meant to him, and to them, to have some final time together. He told of his deep faith and how he felt that as long as he could think and feel and love, his life had meaning. He thanked the young physician for giving him those three months, and he absolved the young physician of any blame for the terrible suffering he now felt. And as always, "Have a nice day, doc."

The young physician was stunned as he left the dying man's bedside that night. It was his first true lesson in being not just a physician but in being a compassionate physician. He had been taught that each person is a distinct individual and that being judgmental about patients' decisions was not part of doctoring. The dying man had taught him that for some patients the gift of even a few days might be the most precious time in a patient's life. He had been humbled in the face of great dignity. And the lessons taught by that dying man became ingrained in the young physician.

The man long dead and the young physician have come to mind frequently in recent months. Health system reform is already well underway. It is apparent that managed care will be THE delivery vehicle in the future. Quality is being redefined to fit parameters and outcomes – and cost/benefit analysis. This redefining of quality has been given a palatable name, it's called finding "value" in medicine. There will be a limiting and a rationing of services in the guise of "improved quality." The decisions of medicine will be reduced to the algorithm of disease. We are told this new

world of managed care will be a great improvement in quality, and we will save money as an added benefit. Perhaps for society this may be true.

But what of the dying man and the young physician? The dying man made a very suspect decision. His outcome was certain. From the parameters of suffering and health, his decision to preserve kidney function was horrible; trading quick and peaceful death for being eaten alive by cancer. And from a cost/benefit perspective, his decision was a disaster. So much money expended for three months of pain and misery! But how can anyone, especially managed care protocols, "value" what that dying man did

with his three months? How can managed care place cost/benefit analysis on the love the dying man shared with his family and friends in those final weeks? Will managed care allow future dying men to make the choice this dead man made? Will health care of the future recognize that the individual patient simply isn't a uniform set of diseases that fit a flow chart in an accountant's spreadsheet? Indeed, in the future, would the dying man be allowed to be human and make human choices?

And the young physician? He is older now. He fears for the future. The dead man (and many other patients) taught him to bring the "human" element into his art

and science. Must he now give this up? He also knows that someday he will be a patient, and perhaps even a dying man with dying-man decisions to make. Will he be allowed to make his own choices? The physician fears that he will soon no longer be able to sit with other "dying men" and make such exquisitely personal decisions that the dead man made so long ago. He fears that in the impersonal, regimented, guided, parametered, outcomed, cost/benefited, "value" health system of the future he may never hear once again, "Have a nice day, doc." □

The author is a urologist in private practice in Evansville.

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Licensing board's duty:

Bob Carlson
Indianapolis

Physicians who abuse drugs or alcohol or engage in other illegal acts while practicing medicine run the risk of becoming one of the approximately 20 new cases referred annually to the Medical Licensing Board of Indiana.

"It's surprising, the variety of problems physicians can get themselves into," says N. Stacy Lankford, M.D., current president of the MLB. In this conversation with *INDIANA MEDICINE*, Dr. Lankford talks about the problems that bring physicians before the board and describes in detail the sanctions the board can impose. He explains how impaired physicians can get help. He cites the Indiana law that obligates physicians to report professional impairment or misconduct. And finally, he shares the emotional lows and highs of sitting in judgment on his colleagues.

After graduating from the Indiana University School of Medicine, Dr. Lankford completed a general surgery internship at the IU Medical Center and a residency in surgery in the department of urology at the IU Medical Center. A board-certified urologist who practices in Elkhart, Dr. Lankford was appointed to the Medical Licensing Board in 1992 and previously served as its secretary and vice president.

INDIANA MEDICINE: What are your duties as a member of the Indiana Medical Licensing Board (MLB)?

Lankford: The essential duty is to protect the public and the citizens of Indiana. Usually it is a matter of reviewing licensure applications and of having hearings for doctors

who have had charges filed against them or actions brought against them by the attorney general's office. Most of our time is spent with administrative hearings.

INDIANA MEDICINE: How is an individual appointed to the MLB?

Lankford: We are appointed by the governor. All seven members serve at the pleasure of the governor and can be removed at any time. [The board must consist of six physicians and one consumer member.] There is a four-year term for each member. We have people in their second term, and Ron Elberger, the consumer member, is now in his fourth term.

INDIANA MEDICINE: Can you give us a typical sequence of events, starting with an action brought against a physician by the attorney general's office?

Lankford: The medical licensing board does not have an investigative arm. We act only on cases brought to our attention by the attorney general's office, which investigates the complaints against physicians. Once the attorney general's office feels it has a case that warrants our attention, it notifies us. We are basically the judge and the jury, and we decide, based on the evidence that the attorney general presents, the evidence the physician and his or her counsel present, and the evidence that we can determine by asking questions ourselves.

If it is an emergency, we have a teleconference. The attorney general's office presents the case, and then the MLB decides whether or not the physician represents a clear and immediate danger to



To protect the public

public health and safety. If that is the finding, then we would vote for an emergency suspension. If we find it is not an emergency, then we may have the doctor appear at the next meeting to hear the charges brought against him or her and determine what needs to be done at that time.

We don't always agree with the attorney general's assessment that emergency suspension is indicated. If the facts presented do not warrant any action, then we are not notified of the name of the practitioner. If we decide to suspend or ask the physician to appear at a hearing, then the deputy attorney general reveals the name of the physician to us.

INDIANA MEDICINE: Who in the attorney general's office handles these cases?

Lankford: There are four lawyers that present cases to us. They are in the consumer protection division. I think they do a very good job of presenting their side and understanding the facts of the case from their perspective. In general, the attorney general's office does an excellent job. Unfortunately, I think they are understaffed, and they have many more complaints to deal with than they have manpower.

INDIANA MEDICINE: The teleconference happens only in the event of an emergency?

Lankford: Correct. If it is not an emergency, the case will often be presented verbally by the attorney general's office at a regularly scheduled board meeting. The attorney general represents the state, so that office is actively

involved in all of our meetings. The physician would appear at the next scheduled licensing board meeting to present his or her side, with counsel if the physician chooses, and we would then determine whether or not the physician should be suspended.

INDIANA MEDICINE: How and why does the MLB suspend a medical license without a hearing?

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The medical licensing board does not have an investigative arm. We act only on cases brought to our attention by the attorney general's office, which investigates the complaints against physicians.

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Lankford: That is a very important point because most people think the physician should have his or her side heard, and we agree that they should. If the attorney general's office thinks it has an emergency case and it has the evidence to back it up, then it notifies Lisa Perius, the director of the medical licensing board. She then notifies us and tries to determine when we could have a quorum. We try to have all members present, but we must have at least four to have a quorum. At that time, the phone calls would be generated, and we would be on a

conference call with the attorney general's office, which would present its case. At the end of the presentation, we would ask questions, and then we would decide or vote on what action, if any, to be taken.

Our choice of action on an emergency suspension teleconference would be to suspend or not to suspend. The suspension could take place immediately if there is a clear and immediate danger – for example, if the physician had been abusing chemicals or is an alcoholic and is practicing in an impaired state. If that was proven to us by the attorney general's office, that would call for an emergency suspension, which would take place immediately. The first notification that the physician would have would be immediately after the suspension. If the board determines that the criteria for emergency suspension are not met, then the physician will not be suspended. The physician then could be asked to appear at what is called a “show cause” hearing.

INDIANA MEDICINE: In the event of an immediate suspension, does somebody from the board or does



the attorney general's office notify that particular physician?

Lankford: It depends on where the physician is and what the circumstances are. Sometimes these physicians who are suspended as an emergency are in jail. Sometimes they are in treatment programs for alcoholism or drug dependency. Usually they are notified by the MLB staff, possibly by the police.

INDIANA MEDICINE: What are some of the reasons that physicians come before the MLB?

Lankford: Probably the most common is chemical dependency – alcoholism or drug abuse. Other examples include using drugs for other than medically indicated purposes, writing prescriptions for individuals who don't need them for medical purposes, selling prescriptions to someone for the narcotics, giving patients prescriptions without examining them in return for an office call fee. Occasionally physicians themselves are not abusing the drug but may be prescribing improperly.

Other problems that we have seen recently include sexual misconduct. There seems to be an increased awareness of that or at least an increased reporting of it. Physician incompetence is another problem. Sometimes elderly physicians who have not kept up to date on current theory of medical practice may come before the board. Far and away the most common, however, are alcoholism and drug abuse.

INDIANA MEDICINE: Are you saying that alcoholism is at the top and then come other forms of drug

abuse?

Lankford: The board and the people who involve themselves in treating physicians, or anyone with chemical dependency, consider it chemical dependency whether it is alcohol or drugs because most cases involve both. It is rare that someone just abuses alcohol or just abuses drugs. It is usually multiple chemicals, although there are cases in which there is abuse of narcotic cough syrup or just alcohol. But this is still considered chemical dependency.

INDIANA MEDICINE: Including emergency suspension, which you talked about earlier, what are the different actions that the MLB can take against a physician?

Lankford: There are four of them. One is a reprimand. A letter can be sent to the physician that indicates a deficiency in his practice. For example, if a patient has moved and the physician is not releasing the medical records to that patient, we might write a letter of reprimand, saying please be more timely in providing your patients' records to them. That would be all there would be to that, providing the physician complies.

The next action would be suspension. Suspension is when the board has determined the physician is not capable of practicing competent medicine. In an effort to protect the public, we would suspend the physician so he or she would not be able to see patients professionally. We suspend the license only for 90 days at a time. After 90 days, we hear the case again and then decide on whether we should



continue the suspension. A lot of these physicians who may be involved in a long drug treatment program and are not out of the program yet would continue their suspension until the program is completed or, in the case of imprisoned physicians, suspensions are continued until there can be a final hearing.

During the suspension, a physician doesn't work. A suspension is only a temporary means to keep physicians from re-entering any kind of medical practice if, for example, they have a serious chemical dependence problem and are either in treatment or planning to enter treatment soon. Once physicians have gone through treatment and proven to the board that they can comply with terms and conditions of a reasonable probation, they would be given license to practice under the terms and conditions of probation.

There have been occasions where, for example, the physician is an alcoholic, has been in treatment and then for some reason is reported and brought to the attention of the board. If the

physician is practicing competently, we would probably ask the physician to sign a contract with the Commission on Physician Assistance of the Indiana State Medical Association for after-care monitoring, again to ensure the physician practices safely.

Number three is probation. That sounds like it comes after suspension, and it usually does. But sometimes we begin with probation. Probation includes terms and conditions under which the board feels the physician can practice safely. The terms and conditions are clearly laid out and they are usually numerous – sometimes 10 or 15 terms and conditions can be given. For example, the physician must attend Alcoholics Anonymous, comply with the requirements of the ISMA Commission on Physician Assistance and so on, depending on what the problem is. Maybe their DEA (Drug Enforcement Administration) number will be taken away. If it is a sexual misconduct case involving a male physician, [a probation condition might require] having a female chaperone present when female patients are being examined. If it is a case of child sexual abuse, it would be making sure that the physician was never alone with a child in a professional capacity. So probation, although it sounds like it would follow suspension and usually does, can also be rendered immediately after a hearing.

Probation extends for a certain period of time, and at different points of time down the road, the physician is allowed to petition the board at a hearing to change the terms and conditions of the probation. If a physician has not had a DEA number and for a

period of two or three years has had no problems, the physician can reapply for the DEA number. If the board feels that the physician can now safely write narcotic prescriptions, we might permit them to reapply for their DEA number but would ask the physician to provide a log of those controlled substances. If the act the physician originally committed is egregious enough, we may put the physician on indefinite probation. If it is a lesser event, it may be a two-year probation, a five-year

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We desperately want physicians to be rehabilitated and reintegrated into the practice of medicine.
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probation, 10-year probation. It just depends. During that period of probation, the physician appears before the board at whatever intervals of time we would determine. If it is a severe problem, the physician appears monthly for the first year or two, and then less often if the problem seems to be remedied.

Number four is revocation. That is removal of the license for a period of seven years. After seven years, the physician can reapply for licensure, take the appropriate tests and regain full licensure. Revocation is for the most egregious acts, and in my two-and-a-half-year term on the board, I have not seen a case where we have revoked. But there have been cases of physicians who have had their

license revoked and have regained their license. Some physicians have served federal prison time for drug diversion or drug abuse and, after their term of revocation, are back in practice with terms and conditions. Most of these physicians are on probationary status. I think most people think revocation means that one would never be able to practice again but, in fact, it means only for seven years.

INDIANA MEDICINE: What is the role of the MLB in the rehabilitation of an impaired physician?

Lankford: Speaking for myself, I don't think the MLB considers itself responsible for rehabilitating

Medical Licensing Board members

- N. Stacy Lankford, M.D., president, Elkhart
- Patrick Russell, D.O., vice president, Elkhart
- John Wernert, M.D., secretary, Indianapolis
- Keshav Aggarwal, M.D., Hobart
- Ralph Stewart, M.D., Vincennes
- Alexander Williams, M.D., Gary
- Ronald Elberger, consumer member, Indianapolis □

the impaired physician. We are responsible for the health and safety of the public. We desperately want physicians to be rehabilitated and reintegrated into the practice of medicine, and we rely heavily on the ISMA's Commission on Physician Assistance to describe guidelines in what is called a contract so that physicians can be monitored to be sure they are complying with the terms and

ISMA can help impaired doctors

The Indiana State Medical Association Commission on Physician Assistance (COPA) addresses the needs of physicians impaired by chemical dependence, psychiatric disorders, physical disability and organic brain syndrome. Services offered include intervention, assessment and treatment referral and monitoring and advocacy services.

According to federal law and ISMA program policies, all participant information is confidential. Impaired physicians are reported to the Medical Licensing Board only if they fail to comply with the prescribed treatment plan.

If you are concerned about a physician and don't know what to do, call the ISMA COPA for assistance Monday through Friday, 1-800-257-4762 or (317) 261-2060. □

conditions of the probationary period. Our primary responsibility is to protect the public.

However, the licensing board thinks very highly of and depends heavily upon the Commission on Physician Assistance, and we think it does a wonderful job of helping physicians become rehabilitated. They are not the treating physicians, but they help us ensure that these people are safe to return to the practice of medicine. It is not our intent that physicians cease to practice. We want them to return, and we think that the Commission on Physician Assistance is key to that success.

INDIANA MEDICINE: If a physician knows of another physician practicing while impaired, what is a physician's duty under the law?

Lankford: I can read you the law. It is under *Peer reviews* of the Indiana State Statutes. It says under Section 8, "A practitioner who has a personal knowledge based upon a reasonable belief that another practitioner holding the same licenses has engaged in illegal, unlawful, incompetent or fraudulent conduct in the practice of medicine or osteopathic medicine, shall promptly report such conduct to a peer review or similar body as defined in IC [Indiana Code] 34-4 -12.6(c), having jurisdiction over the offending practitioner and the matter. This provision does not prohibit a practitioner from promptly reporting said conduct directly to the medical licensing board. Further, a practitioner who has personal knowledge of any person engaged in, or attempting to engage in, the unauthorized



practice of medicine or osteopathic medicine shall promptly report such contact to the medical licensing board."

We don't want people to think they need to be a snitch, but when there is a serious problem that does seem to affect the physician's ability to practice, we feel that it is important that physicians report that, preferably to a peer review committee at the hospital where they are working. If that is not available, then to the medical licensing board.

I also want to point out something about the Commission on Physician Assistance. If a physician or a friend of the physician or a colleague believes that a physician is impaired, and if the physician voluntarily submits himself to the commission, it can arrange for the physician to have treatment, and it will never be known to the MLB, providing that physician complies with the contract. However, if that physician begins drinking again or doesn't comply with the contract, the physician will then be reported to the MLB. The ISMA Commission on Physician Assistance sees the majority of [impaired] physi-

cians, approximately 60%. These are people who have voluntarily submitted themselves, at the urging of colleagues usually, or family, and are getting help, undergoing treatment. The medical licensing board doesn't even know who they are because they are complying with the program, getting help and reintegrating themselves into medicine.

INDIANA MEDICINE: What has your involvement on the MLB done to your perception about your profession?

Lankford: It is surprising, the variety of problems physicians can get themselves into. It has become clear that it is extremely important, especially for impaired physicians, to be identified and treated early because when we see physicians who have gotten to the point where they lose their license, it is often after they have lost their family, their practice, everything. When they lose their license, they finally get interested in being treated. That to me is the most shocking thing – how someone could have a chemical dependence problem and have lost everything except their license and only when they lose that will they seek and get effective treatment. It would sure be nice to think that it didn't

take that, that somewhere along the line they would recognize their problem and be treated before everything is lost.

INDIANA MEDICINE: What are your personal feelings about your work on the MLB?

Lankford: It has been a rewarding experience, and I hope what I have done has been done in a fair way. In fact, according to the rules of the board, if any member feels that he or she can't render an impartial decision, that member must excuse himself or herself from the hearing, and occasionally that does happen. I think it is a very important job. It is a public service responsibility, and I have always tried to do some public service through my professional career. I enjoy this more than any other public service activity that I have been involved in. I think that all physicians need to be concerned about the quality of medical care that is delivered. This is the way that I personally thought I could do the best job for my colleagues.

INDIANA MEDICINE: What is the toughest part of serving on the MLB for you personally?

Lankford: The toughest part is to see a physician, especially a

chemically impaired physician who has not yet gained insight into his problem, who continues self-destructive behavior. I am thinking of a physician who came before the board with a chemical dependency problem. His response to the board was that he would just stay suspended or surrender his license. He had no desire to have a hearing, presumably then go through treatment or whatever. I have no idea what he had in mind, but he didn't choose to fight to keep his license at all. I suppose that is the most distressing part of the job I see. It is, fortunately, not a very common one because most doctors who get in trouble go into treatment and do marvelously well. It is wonderful to see someone who has gone from total denial of the problem, fighting and resisting treatment, then entering treatment and seeing a total change, a different person, a positive person who is not depressed, sometimes reestablishing family ties with their kids or their spouse. That happens a lot. It almost makes you get tears in your eyes to see some of these physicians who turn it around. It is unbelievable. □

The author is a health care writer in Indianapolis.

Peer review shifts focus to patterns of care

Bob Carlson
Indianapolis

Not long ago, letters from peer review organizations (PROs) invariably meant trouble. Your patient couldn't be better, but something, maybe a gap in documentation, caught a case reviewer's eye. And now this letter from the PRO is asking you to defend what the chart says you did. Or didn't do. *Gross and flagrant error?* Yes, doctor, that's you they're talking about.

Individual case review antagonized a lot of physicians. It also wasted a lot of time, and it wasn't very productive at all in terms of improving quality of care. Fortunately, there was a better way.

New role for PROs

As a result of changes initiated by the Health Care Financing Administration (HCFA), PROs are moving away from "dealing with individual clinical errors toward assisting physicians and hospitals improve the mainstream of care through variations research and principles inherent in continuous quality improvement," according to a PRO resource guide published by the American Medical Association.

HCFA changed peer review "because it would be possible to have a greater impact on improving care for Medicare beneficiaries by improving the mainstream of care than by trying to shoot the rotten apples in a barrel," says Stephen Jencks, M.D., senior clinical adviser for the Health Standards and Quality Bureau at

HCFA. Dr. Jencks is responsible for the Health Care Quality Improvement Project (HCQIP), which is revolutionizing the way PROs across the country do business.

What Dr. Jencks is talking about is the theory and practice of quality according to Deming, Juran and others, the holy grail of business and industry throughout the world ever since the Japanese first demonstrated its virtues in the 1970s and 1980s. "It's the difference between having an inspector at the end of the production line culling out the defectives and trying to get the production line tuned so that it is in control and producing the minimum number of defects," explains Dr. Jencks. Applying that analogy to health care, Jencks says that looking at patterns of care, rather than engaging in very unproductive hindsight on how an individual case should have been managed, will in the long run do more good

for patients and help physicians practice better medicine.

"Physicians are trained to think that we have to do it all," says Jencks. "But we all need to function in systems that are resistant to failure." Building failure-resistant systems by introducing total quality management and continuous quality improvement methods to American health care is what HCQIP is all about.

In the Medical Peer Review Organization Fourth Scope of Work, HCFA defined the new contractual obligations of PROs beginning April 1, 1993. The theoretical component of the Fourth Scope of Work, the HCQIP, articulated the shift away from dealing with individual clinical errors and toward analyzing patterns of care.

PROs will continue to do random sample case review until 1995, albeit at a reduced volume, and a documented medical record would still be the essential element of the new Quality Review Process (QRP). But henceforth, PROs would be in the business of analyzing patterns of care, comparing outcomes with national criteria, sharing that information with physicians and hospitals and helping them to identify ways to improve quality of care and outcomes.

Variations research and the principles of continuous quality improvement, the same methods that helped the Japanese, and belatedly Detroit, build better cars, are now helping to improve the quality of health care in America.

The AMA has played a key



Phil Morphey

role in reshaping the PRO program. The AMA "will monitor the implementation of the PRO Fourth Scope of Work and will continue to work with HCFA to direct the PRO program in an educational, non-punitive manner consistent with AMA policy."

IMRO changes focus

What Indiana's PRO does and who is doing it continue to change dramatically under HCQIP.

Indiana Medical Review Organization, Inc. (IMRO) has assembled a brain trust of Ph.D.s and M.D.s with credentials in mathematics, biostatistics, outcomes research, epidemiology and public health to analyze clinical data and to work with physicians and hospitals. Headquartered in Terre Haute, IMRO also has the PRO contract for Kentucky, where it is known as Kentucky Medical Review Organization.

"Between the two states, we have over 40 local cooperative projects in various stages," says IMRO chief executive officer Phil Morphew. "We're very excited. As physicians and hospitals begin to learn about this, we think they are going to be very receptive to this as the alternative to individual case review."

Morphew is keenly aware of physician disenchantment with the way PROs used to do business. "With individual case review, the only time physicians heard from us is when they got these letters about something negative or potentially negative," recalls Morphew. "Understandably, that created resentment out there in the physician and hospital community, particularly when they did nothing wrong, or disagreed with our finding, or felt that we missed

something in the medical record."

Under HCQIP, it's a whole new story, says Morphew.

"Our primary objective in selecting cases is to glean clinical data from the record. These data are used as the basis for collaborative activity such as the HCQIP local cooperative projects with hospitals and doctors that will enable us to give positive feedback to the health care provider community in terms of what we have accomplished together. I believe it will place a whole new slant on the concept of external review. It is not going to be punitive. It is not going to result in denial of payment. It is going to result in changing patterns of care."

What can Indiana physicians learn from HCQIP local cooperative projects?

"I think it is a question of what we will all learn together, physicians, hospitals, the people in the PRO and others who are interested in the process," says Morphew. "For example, Dr. Chris Bailey [commissioner of the Indiana State Department of Health] is a member of the steering committee representing the ISDH. What we as a community should learn is what works and what doesn't and what is the level of current compliance with currently accepted practice guidelines. If that level of compliance is less than desirable, what methods help move us to greater compliance? I think that each time we take on a local cooperative project, the physicians involved will have to evaluate what will work most effectively for them in that hospital."

Local cooperative projects

Along with other PROs around the country, IMRO will be participat-

How to contact IMRO

The Indiana Medical Review Organization (IMRO) welcomes ideas and comments from physicians. Please address them to Peggy Chandler, Ph.D., Director of Research and Analysis, Indiana Medical Review Organization, P.O. Box 3713, Terre Haute, IN 47803. □

ing in national cooperative projects under HCQIP. Right now, however, IMRO's plate is filled with more than 40 HCQIP Local Cooperative Projects. Project titles include "Missed Opportunities to Treat Tuberculosis with New CDC/ATS Guidelines," "Identifying Transfusion Practices Which Are Successful in Preserving the Blood Supply," "Correlation Between Admission and Mortality Rates by HSA for 17 Major Diagnostic and Procedure Categories" and "Radical Prostatectomy."

John N. Lewis, M.D., M.P.H., is one of two (soon to be three) clinical coordinators at IMRO responsible for managing these projects. Dr. Lewis is a graduate of Johns Hopkins University School of Medicine and received his M.P.H. from Harvard University School of Public Health. He is board certified in internal medicine. Before joining IMRO earlier this year, he worked as an epidemiologist with the Epidemic Intelligence Service of the Centers for Disease Control and Prevention, the National Institute of Occupational Safety and Health,

the Connecticut State Department of Health, the Virgin Islands Department of Social and Health Services and the Baltimore City Health Department.

According to Dr. Lewis, local cooperative projects usually take about nine months to complete. Because IMRO initiated these projects in May and June of this year, final results will not be forthcoming until early 1995.

Ideas for projects come from various sources, including HCFA, a member of the community or the professional analysis of large administrative databases. IMRO staff begins the project by reviewing a sample of charts of people hospitalized with a particular problem, analyzing the data and then developing an idea of some hospitals it wants to focus on. Dr. Lewis said IMRO approaches the hospitals as partners, asking them if they would cooperate with IMRO on the project. "From then on, we work together in terms of gathering more data and coming up with an action plan," said Dr. Lewis.

"Missed Opportunities to Treat Tuberculosis with New CDC/ATS Guidelines" is one of the projects Dr. Lewis is studying. Since learning that the number of hospitalized Medicare patients with a recorded diagnosis of tuberculosis was much larger than the number of patients in that age group reported to the state, he is trying to analyze why that happens. "That's something I'll only learn by really working together with the hospitals," he says. "Incidentally, the hospitals I have talked to have been very open to this and willing to work on it."

Dr. Lewis is also focusing on the treatment of tuberculosis. "I

thought this would be a particularly good project because the national practice guidelines on TB treatment have changed within the past year," he says. The new guidelines include the recommendation that TB patients be started on four drugs in an effort to prevent the multidrug-resistant tuberculosis that is occurring.

"Identifying Transfusion Practices Which Are Successful in Preserving the Blood Supply" is another issue Dr. Lewis is studying. "This is a project I'm working on because of interest by Donna Shalala, the Secretary of Health and Human Services, and Elizabeth Dole, head of the American Red Cross," he says. "We've focused on the area in southern Indiana and northern Kentucky that is supplied by the Red Cross out of Louisville, Ky." After discovering that 12 hospitals used less blood than expected, IMRO researchers are looking for the reasons behind that so they can develop some recommendations for other hospitals.

Physicians can expect to learn the results of these studies in two ways, Dr. Lewis says. Hospitals will share with physicians any results they receive from IMRO. For example, infection control committees might communicate information about standards of care for tuberculosis.

IMRO also hopes to send out results of some projects in newsletters and other material that goes to physicians. "I think we need more communication directly with physicians about the things we're learning from these projects," Dr. Lewis said. "In the future, I think we're going to get more into an educational role and more into communicating benchmark

information about medical care."

A kinder, gentler PRO

John D. Slack, M.D., is a practicing cardiologist with Nasser, Smith & Pinkerton Cardiology in Indianapolis. Dr. Slack started doing chart review for IMRO about seven years ago and now also serves on IMRO's analysis and steering committees.

While he gives HCFA credit for recognizing that individual case review had run its course, he maintains that the process did improve documentation throughout the medical community. "That's been to the benefit of our patients and also, frankly, to physicians," says Slack. "I think we're much less exposed to medical-legal concerns because we're so focused now on our documentation in the medical record."

Not only will physicians work with a "kinder, gentler PRO," in Slack's words, but HCQIP will also improve medical care. "I think this type of data collection, data analysis, data sharing, dialogue and education from both sides will benefit our patients as well as our profession," he says. "I don't know any physician that isn't interested in providing better patient care. I think physicians are actually going to like this."

HCQIP may also be a timely antidote to what Dr. Slack sees as increasing professional isolation. "Doctors are clustering closer to their hospitals," he notes. "I'm afraid you're going to develop practice patterns within each individual hospital rather than within each region. I've found that when physicians are presented with good data on how they're practicing, they'll do whatever is

necessary to change their practice patterns. But if there's no dialogue, then you become very inbred."

As a member of IMRO's steering committee, Dr. Slack participates in the feasibility review of ideas for local cooperative projects. He is also one of three practicing physicians on the analysis committee, which monitors the progress of projects and the appropriate changes in provider practice patterns. He encourages physicians to become more involved with utilization and quality committees in their hospitals and also to volunteer their services to IMRO.

"There are never enough physicians actively involved in this process, and if physicians don't participate, the process won't stop," cautions Slack. "Non-physicians or non-practicing physicians will become dominant in the process. And personally, I don't want my work reviewed by people who aren't practicing physicians."

IMRO in your future

For IMRO and other PROs, the focus continues to be the Medicare population. The continuing improvements in health care quality resulting from HCQIP's new peer review process, however, are likely to benefit everyone.

"If a medical staff decides to adopt a new policy, that would appear to me to benefit more than just the Medicare population," reasons Morphew. "We would not expect physicians to differentiate between the way they practice with Medicare patients and how they practice with an Aetna patient, a patient insured by the Associated Group or a patient

enrolled in an HMO."

Morphew speculates that in the future, the federal government may even become a relatively minor funding source for PROs. Private businesses, payor organizations and health care provider organizations may contract with PROs who, along with other entities such as the state health department, universities, state hospital and medical associations, provider networks, managed care networks and citizen groups, may evolve into health care quality improvement foundations for regional communities.

"That really is the vision we are committed to begin working on," says Morphew. "By the year 2000, it could actually displace the PRO program. That means bringing a lot of people to the table and talking about the future. We hope to do that. After all, we're all interested in improving the health status of the people of Indiana."

His message to Indiana physicians?

"Support these changes in every way you can. Work with us. Find ways to support local cooperative projects. Physicians and hospitals who collaborate with us have shared ownership of these projects. In a larger sense, the projects belong to the people of Indiana because we believe they will permit physicians to improve care for the general population. Send us your ideas for projects. Send us your critiques of what we are doing and your input so that we can be truly useful to the physician and hospital community in Indiana."

Daniel J. Combs, M.D., a board-certified internist practicing in Vincennes, is a reviewer for

IMRO and a member of ISMA's Liaison Committee with IMRO. He sees IMRO's work contributing to better patient care and increased efficiency. "I think with the coming of managed care in a big way to Indiana there's going to be a big emphasis on developing a process that gets patients in and out of the hospital in a quality manner," says Combs. "We're going to have to be much more efficient. The less amount of time you have somebody in the hospital, the less chance they have of developing a hospital-acquired infection and the less it's going to cost."

Dr. Slack concurs. "The use of pattern analysis and statistical review is with us to stay. Not only is IMRO looking at these data, but insurance companies are looking at similar data. We have to embrace these efforts. We have to try to ensure that the best data available are there for analysis. And we have to expect feedback so that we can evaluate the data and adjust practice patterns as necessary."

"We are building a PRO system which is a useful and trustworthy ally and partner of physicians in improving quality," says Dr. Jencks. "Physicians should see whether just possibly this might be helpful to them. They might find that these folks are interested in being partners rather than problems." □

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The author is a health care writer in Indianapolis.

The new frontier for physicians: Revenue-focused

Kameron H. McQuay
Indianapolis

We are in the early stages of a new health care delivery system, whose core is as fundamentally different from its predecessors as radio broadcasting was with the introduction of television in the early 1950s. If you grasp this premise, it is easier to understand what is going on around you, including why an unrelenting tide of change keeps washing over you and your practice. As with any such movement, the ability to recognize the new delivery system for what it is, track its progress and then foresee its consequences could be crucial to prevailing during, or maybe just surviving, this reformation.

A key to surviving health care reform will require you to change your view from the established fee-for-service reimbursement system and cost-

containment philosophy of the 1980s to a new frontier of capitated arrangements with a focus on revenues, not costs.

It has been said that the United States is now witnessing the largest industrial reorganization since the 19th century – the corporatization of American health care. It also has been stated that it is virtually impossible to overestimate the enormity of the task facing traditional providers in preparing for this new environment. At a time when physicians

are still grappling with and adjusting to the requirements of government programs, precertification and aggressive utilization review, the next challenge on the horizon comes at what seems like lightning speed.

The new challenge is managed care. In more developed markets, managed care quickly becomes capitation, a system that in its simplest definition prospectively pays physicians a set per patient rate to provide all needed care for a specific patient population.

One can hardly open up a medical business journal without the virtues of reducing overhead expenses and streamlining business costs being touted, all in an effort to prepare for managed care.

Therefore, to capitalize on this new market, physicians and other health care practitioners must begin to rethink the entire process of being compensated for services.

Overhead expenses have increased significantly in the last 10 years, with the largest impact on primary care physicians. In view of such facts, it may be difficult to argue that reducing practice expenses is an erroneous business strategy. There is little doubt, however, that all these energies are misguided. Although most of the new health care delivery systems succeed at some level in reducing practice overhead costs, practice costs are – and must be – viewed as a secondary issue. At the heart of this new health care reformation is the

ability to increase revenue by securing patient lives and increasing market coverage.

A central theme and critical issue in the vertical integration of health care delivery is the possibility of being locked out by a more powerful medical group or delivery system through exclusive payer contracts. If this occurs, medical practices will be forced to rely solely upon the shrinking fee-for-service business to sustain their practices.

Therefore, to capitalize on this new market, physicians and other health care practitioners must begin to rethink the entire process of being compensated for services. Under the old fee-for-service systems, doctors would provide

care, submit their bills and then wait for reimbursement. Under health care systems such as managed care and capitation that are emerging today, the process is far more straightforward.

Physicians are paid,

in advance, a specific fee for total care for each patient covered under the health plan's program.

Under this new environment, it will no longer be important how many patients you see or how many procedures you perform, but rather how many lives you cover and how efficiently you provide the appropriate services.

The focus, therefore, should not be on costs but on revenues and the ability to attract and retain paying businesses with valuable employee contracts.

While the benefits of reducing

practice costs have merit, it pales in comparison to the impact – both positively and negatively – of your existing revenue stream and the patient base you have worked so hard to establish.

Twenty years ago, it was good enough to provide quality care at affordable prices in hopes of developing a good reputation and securing patients through word-of-mouth. In the new health care systems developing today, word-of-mouth referrals, while appreciated, yield few if any patients. Instead, patients will be directed to physicians based on what insur-

ance plans they have and what providers participate in that plan. And while it might be nice to cut 2% off your overhead percentage, a loss of just one managed care contract could result in thousands of dollars of lost revenue.

Instead, physicians need to actively and aggressively position their practices in the marketplace, concentrating their efforts on securing productive revenue streams, converting their focus from fee-for-service reimbursement to patient lives and building primary and multispecialty physician networks to compete on

a local and regional basis while providing low-cost, high-quality care.

Physicians who adapt to this health care reformation and keep their eyes focused on the multitude of revenue streams that exist stand the best chance to succeed in the future. □

The author is a manager and director of physician services with Blue & Co., LLC, consultants and certified public accountants, in Indianapolis.

Look-alike and sound-alike drug names

	CHOLOXIN	CHLOROXINE
Category:	Antihyperlipidemic	Antiseborrheic
Brand name:	Choloxin, Flint	Capitol, Westwood Squibb
Generic name:	Dextrothyroxine sodium	Chloroxine
Dosage forms:	Tablets	Shampoo
	DERMATOP	DIMETAPP
Category:	Corticosteroid	Decongestant-antihistamine combination
Brand name:	Dermatop, Hoechst-Roussel	Dimetapp, Robins
Generic name:	Prednicarbate	combination drug
Dosage forms:	Cream	Tablets, elixir

■ drug names

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

The death of Wolfgang Amadeus Mozart

Robert L. Rold, M.D.
Newburgh

The 200th anniversary in 1991 of the death of Wolfgang Amadeus Mozart prompted renewed interest and speculation about his life and, possibly, even more about his death and burial. The events culminating in his demise continue to be a blot on the collective human conscience. He was one of the few true geniuses in human history, and he struggled manfully and ultimately pathetically for the recognition and rewards he so richly deserved.

In tragic irony, the city that was the heart and soul of the musical world failed to celebrate the greatest musical genius of all time, and on Nov. 7, 1791, it interred him in an unmarked and now lost common grave with about 15 other Viennese dead.¹ There was a small funeral service in a corner of St. Stephen's Cathedral, but no family member or friend was present at the cemetery.

In just over 35 years of life and perhaps 20 years of mature productive activity, he gave the world a legacy of music unsurpassed by anyone, including his two great contemporaries, Haydn and Beethoven. Until the final illness, he led a relatively normal life from the standpoint of health and happiness. Sure of his gifts, generally congenial, very industrious and mostly happy, he lived life as a normally healthy man. He did indeed have illnesses both as a child and as an adult, just as we all do. One or two of these were fairly significant but nothing resulting in a chronically ill, slowly deteriorat-

ing adult as has been suggested by several writers. Mozart did not live the life of a man with a chronic debilitating disease. He was always active, both in his creative work and the more mundane social and performance schedules. He rarely missed a performance or social appointment due to illness in his entire life. He was a devoted and attentive husband, and his wife, Constanze, was "always pregnant."

Even in the last years of his life, he was very busy with trips, performances and work. In the last few months of life, his musical output was astounding, even for a Mozart. If chronically ill, depressed and suffering, it never interfered with his sexual activity since he wrote with charming candor and earthiness of this phase of his life into the last year.² So the notion that he died of any chronic illness, heart, renal or otherwise, is quite difficult to defend. As Hildesheimer so eloquently stated, "Mozart did not gradually languish but was suddenly extinguished; he was not slowly worn away but suddenly torn away; no final apotheosis; no 'last glow'; rather the interruption of a mighty creative act of many years duration by a precipitous death."³ So much for chronic disease; now to the rumors of poisoning.

It is time for poor old Antonio Salieri to be completely exonerated of any malicious connection to Mozart's death. No Mozart student gives the theory of poisoning any credence at all. Nor did Salieri have anything to do with the nocturnal visitor who commissioned the Requiem, which turned out to be the composer's last work.

That was the act of Count Franz Walsegg-Stupach, who intended to pass the work off as his own and later did just that. Let the world return to Salieri his good name and reputation and perhaps in recompense mount a brief revival of some of his better music.⁴ He was actually a good man and a good composer – not a great one. If he was guilty of anything, it was the very human trait of self-advancement when confronted with a superior rival. He may deserve no lasting memory as a composer, but he should never have been branded a murderer.

Wagner and Rossini both deserve some measure of shame in helping to establish and perpetuate the poisoning rumor. Also, Pushkin and Rimsky-Korsakoff both profited from the rumor by writing a play and an opera, respectively, based on the poisoning story. In our own time, insult was added to injury by the Peter Shafer play "Amadeus" and the subsequent film by Milos Forman.⁵ Nothing in the film remotely resembled historical fact, and only the music was worthy of mention. It is reasonably clear then that Mozart did not die of poisoning or of a chronic prolonged illness. Therefore, the cause was an acute virulent infection.

The final lethal illness began with fever and swelling of the hands and feet, and within just over two weeks, Mozart was dead. Constanze described her husband's illness as a "sudden fever or that fever which kills suddenly" to a questioner some years later. He apparently soon became unable to move the extremities due to the swelling and

pain, and a special bedjacket was made to fit backward like a hospital gown to facilitate dressing. He was treated with bleeding and compresses to no avail. Death came soon, and the attending physician signed acute miliary fever as the cause, which led to speculation that a rash was present.⁶

The only reliable eyewitnesses to the entire terminal process were Constanze Mozart and her sister, Sophie Haibel. Nicolai Georg Von Nissen, Constanze's second husband and an upper level government official, seized a golden opportunity and published the first Mozart biography in 1828 after his true significance had become known. In doing so, he relied most heavily on the recollection of Constanze and the written recollection of Sophie, whose description of the composer's last day seems to have the most merit.

Visiting the Mozart apartment on the last day, Sophie found her sister very fearful and agitated, stating Mozart had nearly died the previous night. Constanze asked Sophie to go to the sick room to check on him, then to fetch a priest and a doctor since she was sure he had little time left. Mozart spoke to Sophie, and then asked her "to stay and see me die, for I already have the taste of death on my tongue." Sophie was alarmed and made the excuse that she must arrange for her mother's care before she could stay; she promised to return and set off on her grim errand. The priests at St. Peter's were unwilling to visit because Mozart was a Freemason and not in good standing with the Catholic Church; only after much quibbling did one grudgingly agree to see the dying man.

The doctor was another matter. By the time she located him, it was late, and he had gone to the opera; he also would come, but not until after the opera was over.

When Sophie arrived back at the deathbed, Mozart was talking with Franz Sussmayr, his friend and pupil, giving him directions on the completion of the Requiem and still clutching the score. The doctor finally arrived (no one is sure about the priest) and ordered cold compresses to Mozart's forehead. This maneuver had the effect of causing a shudder or shivering, and the patient promptly lapsed into a coma. Death came two hours later. There was some puffing of the cheeks, which some felt related to a tempo in the Requiem but was more likely agonal respiratory effort.⁷

The facts are indeed scanty, but no other information is felt to be reliable by the more sedulous Mozart biographers including Hildesheimer, Braunbehrens and Bar. Yet from a diagnostic viewpoint, the possibilities are not that numerous. The number of diseases with fever, polyarthropathy and possible rash that result in death within two weeks are few indeed, especially when one considers the widespread epidemic illnesses that plagued Europe in the preantibiotic era. Typhus, typhoid, tuberculosis and syphilis have all been mentioned as culprits, but none of them typically take the course of Mozart's illness. Acute post-streptococcal glomerulonephritis has long been held as a prominent possibility in this case. But even the most rapidly progressive crescentic glomerulonephropathy would be very unlikely to complete a lethal



Wolfgang Amadeus Mozart

course within two weeks, according to my nephrology colleagues.⁸ Chronic renal failure from any cause seems to be a poor possibility in light of the patient's premorbid health.

Henoch-Schönlein purpura got a stiff boost in the British medical literature a few years ago but would have to be considered a rare disease in a 35-year-old adult man and rarer still as a cause of death. Additionally, it doesn't explain the persistent burning fever since only half the cases have any fever at all and then only a low-grade elevation.^{9,10} Besides, why look for zebras when the pale horses of death gallop so loudly?

Carl Bar did a thorough investigation of all the circumstances of the case, and felt he had proved the diagnosis of acute rheumatic fever. It is indeed the most likely diagnosis, but it is not proved. No diagnosis ever will be. The Jones criteria are not fulfilled, even though Bar thought so,

considering the rash. He also tried to diagnose childhood illnesses as probable rheumatic fever and a recurrence as the final episode.¹¹ This tactic was probably irrelevant since the acute illness was frequently known to kill. Lulled by the efficacy of modern drug therapy, we forget that before the 1950s rheumatic fever was the cause of 30% to 40% of all heart disease, and both in the acute phase and the chronic valvular stage, it was responsible for a very large number of deaths. Even now, in the developing countries, it is a major killer.¹²

We owe a great debt to those old generalists who seized a major weapon at its advent and treated the throat infections in the '50s, '60s and '70s with penicillin. They certainly overused the antibiotic, probably more than we do now, but they reduced that 30% to 40% to less than 3%.

The literature is rife with other diagnostic suggestions, some so tenuous as to be ludicrous. One English veterinarian proposed malnutrition secondary to chronic mycotoxin ingestion due to ergot contaminated wheat associated with damp weather during the late 18th century.¹³ Another report recently was published of a definitive diagnosis of Tourette's syndrome because of some of the earthy language Mozart used, both in speech and writing. In playful moods, he was guilty of some fairly silly antics with grimaces, hops, skips, etc. He was, as Constanze said, "in all things a child, except music." When he played the piano-forte or any other instrument, however, he was in complete control. There were no grimaces, twitches, gesticulations or words, dirty or clean. There was

only the stare of total concentration and absorption in what he was doing. In fact, he criticized those performers who "emoted" with facial expressions and extraneous motions when they played and thought it detracted from the music.¹⁴ If dirty words and earthy language constitute Tourette's syndrome, it affected all of his family and friends plus 90% of the current population of the United States.

There remains another diagnostic category to deal with – the central nervous system. Apparently because of the reported difficulty Mozart had with motion of the extremities, there was the notion of an intracranial vascular incident, either thrombotic or hemorrhagic. According to some, he became hemiplegic, which is difficult to believe since he spoke quite clearly and alertly to Sussmayr and Sophie on the last day of his life.¹⁵ He was also able to hold the score to the Requiem. And late in the illness, but probably not on the last day as reported, he sang the alto part to a section of his Requiem along with three members of the cast of *The Magic Flute*. One must admit this does not suggest serious brain damage.

In the Salzburg Mozarteum, there is a skull purported to be that of Mozart. It appeared in the possession of a Viennese anatomist about 100 years after the death. The skull history is far-fetched at best. A gravedigger is said to have recognized the body of Mozart, and since he was an admirer of his music, he placed wire strategically on the body so it could be identified later. Then, seven or eight years later, when the grave was opened, he is supposed to have

retrieved the skull, kept it a while and then turned it over to the anatomist where it was kept in the family, then acquired by the Mozart museum in Salzburg.

Anthropologists are said to have examined this skull and diagnosed evidence of intracranial bleeding; that has been used as evidence in support of the stroke theory.¹⁶ The whole thing is just too nebulous to make any difference. Also, the fact that the skull showed evidence of an old fracture seems not to detract from its presumed authenticity. Obviously, no one suggested there was any head trauma before his death. It is quite odd that no cemetery worker was able to point out the grave that held Mozart either a few weeks after the burial or even much later. Yet, one astute employee was able to mark not only the grave, but the body, so he could recover the skull years later. Obviously, there is little to support its authenticity.

There are very few portraits of Mozart, and oddly, none seem to resemble the others, so we really don't have a good consistent idea of his features. A death mask was taken, but Constanze broke it, accidentally we must assume. One admirer with magnifier and imagination felt he detected an ear lobe deformity, only the tip of which was visible beneath the hair in one of the portraits. This little blip has been embellished and intensified like digital subtraction to show a completely deformed ear lobe. Then taking the ear deformity as fact, figures have been produced to show the statistical evidence for congenital renal disease. There is indeed a statistically significant connection between ear lobe deformities and

some types of renal disease, but this incident is too vague for any credibility.¹⁷

Lastly, there was conjecture about psychiatric problems. A British author exuberantly advanced the idea that Mozart was depressed, especially during the last few years of life. He did indeed have some dark moments generated by financial problems. He was totally inadequate in managing his income, and his wife was equally inept. She had multiple pregnancies that resulted in venous stasis, along with other vague symptoms, and came to require extended periods of time at health spas taking curative baths. This was a chronic situation the last couple of years of Mozart's life and was quite expensive.

Always behind financially, Mozart encountered problems with creditors and expenses. Mozart was reduced to begging for loans from a lodge brother, Michael Puchberg. He generally repaid the debts, or so it seems, as best he could, but it was evidently a real struggle. The Puchberg letters make for some sad reading indeed, but to manufacture a psychotic depression from these events is improbable. Leonard Bernstein said it best, possibly from experience, "Depressed composers do not write depressing music; they don't write any music at all." Simple but accurate – people with significant depressions simply can't function. This was hardly the case with Mozart. The last year of his life was one of

his busiest and most productive.

During the past 200 years, many diagnostic possibilities were advanced, some reasonable and logical, others ill-considered. The list has grown long and cumbersome, and a definite pruning is long overdue. A lay biographer wrote that expert medical thought is always welcome, and anything that might contribute to advancing knowledge is worthwhile. He had misgivings, however, about the medical opinions offered, not because of their variety, but the categorical certainty with which they were given.

We will never be certain about the cause of Mozart's death, but curious and thoughtful physicians will never be able to resist the seductive game of diagnosis by history. It would be better, however, to try for more deduction and less dogmatism in our opinions.

Without proof positive, it is most consistent with historical probability, the social environment of the times and the symptom complex and course of the illness, that Mozart died of acute rheumatic fever with possible severe endocarditis and late pulmonary edema. □

The author is a physician in Evansville, certified in family medicine and geriatrics. An avid, lifelong interest in classical music has led to his conclusion that Mozart stands supreme among composers.

Correspondence and reprints: Robert Rold, M.D., 3077 Trailwood

Dr., Newburgh, IN 47630.

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How to settle a dispute without going to court

Tina Sims
Managing Editor

If alternative dispute resolution (ADR) isn't in your vocabulary, perhaps it's time to learn the definition. ADR may be just the solution a physician needs to settle a disagreement with a colleague, a patient or an insurance company without going to court.

ADR is a term that encompasses several methods used to resolve disagreements in settings other than the traditional legal system. The methods include such techniques as mediation, arbitration, settlement negotiation, conciliation, facilitation, mini-trials, summary jury trials, private judges, convening or conflict assessment, neutral evaluation and factfinding, multi-door case allocations and negotiated rulemaking.

Turning to ADR for a solution has several benefits. "The whole point is to try to make it more efficient, economical, accessible and easier to understand," says Cynthia Stanley, an Indianapolis attorney and immediate past president of the Indiana Society for Professionals in Dispute Resolution.

Historically, mediation and arbitration have been the two most commonly used forms of ADR. As defined in the recent Indiana Supreme Court order adopting rules for ADR, mediation is defined as "a process in which a

neutral third person, called a mediator, acts to encourage and to assist in the resolution of a dispute between two or more parties." The same order defines arbitration as "a process in which a neutral third person or a panel, called an arbitrator or an arbitration panel, considers the facts and arguments which are presented by the parties and renders a decision."

"Our hope is that mediation will cost less than going to trial," says Stanley, explaining that this form of ADR can eliminate the need for formal testimony by expert witnesses and full trial preparation by the parties' attorneys. In addition, the two parties normally split the mediator's fee.

Mediation keeps control of the

mediator, says Stanley.

Randolph Lievertz, M.D., has seen first-hand that mediation can work. An Indianapolis family physician, Dr. Lievertz is trained and certified as a mediator.

"Mediation is so new in Indiana that most people don't know about it," he says. The Indiana Supreme Court rules on ADR did not become effective until Jan. 1, 1992.

Dr. Lievertz was in the first ADR class offered by the Indiana Continuing Legal Education Forum (ICLEF). He enrolled at the suggestion of an attorney who knew Dr. Lievertz from his work in medical/legal consultations. Dr. Lievertz's medical/legal work included case reviews of the medical aspects of legal cases,

assistance with malpractice cases and medical research for attorneys.

He is now qualified to do family and civil mediation, is officially certified as

a mediator by the Indiana Supreme Court and is an assistant instructor for ICLEF.

Dr. Lievertz believes that the fact that people get to settle the dispute themselves is the biggest advantage of ADR. "Since you've settled it yourself," he explains, "you're more likely to be happy with it. Since you're happy with it, it's going to last longer."

This characteristic of mediated settlements is called "durability," explains Stanley.

The fact that mediators are trained to propose creative solutions to problems is another advantage of mediation, says Dr.

People also tend to like mediation for another reason - they have a voice in choosing a mediator ...

outcome in the parties' hands, as opposed to having a judge render a decision, Stanley says. And even if a court orders two parties to mediate, they don't have to agree to a solution.

Confidentiality also makes mediation attractive. Mediators must not divulge information that one party has told them unless given permission to do so, and in most circumstances, mediators can't be subpoenaed to testify in court about what the parties have told them.

People also tend to like mediation for another reason - they have a voice in choosing a

Lievertz. In Indiana, mediators come from all professions and include attorneys, psychologists, accountants, social workers and physicians. Forty hours of initial training, followed by continuing mediation education, are necessary for certification as a mediator.

Most people respond positively in the cases he has mediated, he says. "They come out of mediation feeling much better about the process. They don't have a lot of anger."

Dr. Lievertz explains that such reactions are not surprising, considering that ADR is a cooperative effort, whereas lawsuits are an antagonistic effort.

This attitude helps even when mediation does not result in a complete resolution of the dispute, he says. For example, the parties might come closer to a solution than they would have without mediation, or they might settle some, if not all, of the issues in dispute.

When could physicians use ADR? You might find yourself, for example, trying to get reimbursed by an insurance company or caught in the middle of a family's

Speakers bureau offers services

The Indiana Society for Professionals in Dispute Resolution (SPIDR) offers a speakers bureau that can provide a practitioner to speak to organizations on alternative dispute resolution (ADR). There is no charge for the service.

Topics offered include health care mediation, family mediation, insurance mediation and arbitration and the teaching of mediation and arbitration skills.

To find out about other topics or to arrange an informal 30- to 60-minute introduction to ADR, call Cynthia Stanley of SPIDR, (317) 573-0184. □

difference of opinion about how to care for a dying relative, Dr. Lievertz says. ADR also could help physicians resolve disputes within a group practice or with a hospital that is buying their practice; assist with problems between the medical staff and the hospital administration; or settle disagreements between physicians and patients about how to treat an illness. Because medical malpractice cases in Indiana are first heard by a medical review panel, Dr. Lievertz says there is "little incentive" to use ADR in liability

issues in Indiana.

Although Dr. Lievertz says probably very few physicians know about ADR because it is "still basically in its infancy in Indiana," they should not hesitate to try it if they are involved in a dispute that they can't resolve. "Anybody who has an issue they want to take to court should think of mediation," he says.

Physicians shouldn't be concerned if the mediator is not a physician, says Dr. Lievertz. "A good mediator can walk into any situation and mediate it." □

Tax planning for college

Joel M. Blau, CFP
AMA Investment Advisers, L.P.

The cost of a college education has been on a steady rise, increasing at a greater rate than inflation. The College Board has estimated this year's college tuition will increase at an average rate of 6%. This situation has caused many physicians to borrow against the equity of their homes to make the needed payments for school. Unfortunately, most home equity loan interest rates are adjustable. As the prime rate increases, so may your monthly payments.

As an alternative, if you have younger children, you should examine the benefits of making current gifts. Both the Uniform Gifts to Minors Act (UGMA) and the Uniform Transfers to Minors Act (UTMA) provide a simple and inexpensive method of making a gift or bequest to a minor without the expense of a trust. These gifts

will qualify as a "present interest" for the Annual Gift Tax Exclusion of \$10,000 per year for each child, thus avoiding any gift tax liability. Gifts can be used to fund investments such as stocks, bonds and mutual funds. The account titling, though, is very important. An adult, who can also be the donor, is named as custodian under the Uniform Gift (or Transfer) to Minors Act. Also given is the minor's name and Social Security number.

The duties of the custodian require the use of the assets during the child's minority for support, education and maintenance of the minor. The custodianship terminates when the child reaches majority, which is 18 or 21, depending on your state of residence. At that time, the child takes full custody of the funds outright. From an estate tax standpoint, if a donor custodian dies before the child reaches majority, the value of the accounts will be included in the custodian's estate. To avoid

inclusion, a third-party custodian should be named.

The main advantage of this gifting strategy is the income tax benefit. Income on the assets is taxable to the minor, whether distributed or compounded. Children under 14 pay tax at the parents' top tax rate on unearned income over \$1,200. Thus, the first \$1,200 of investment income is taxed at the child's lower tax rate. This tax rate is effectively 7.5% — the first \$600 is tax-free and the next \$600 is taxed at 15%. Once the child reaches 14, all unearned income is taxed at the child's rate.

A word of caution. At majority, the child can withdraw from the account, for any reason and without the consent of the custodian since the custodianship has terminated. □

The author welcomes readers' questions. He can be reached at 1-800-262-3863.

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Index to Indiana Medicine volume 87

January through December 1994

MONTH	PAGES
January/February	1-104
March/April	105-180
May/June	181-262
July/August	263-338
September/October	339-442
November/December	443-514

SCIENTIFIC CONTRIBUTIONS:

E

Endoscopic screening for colorectal cancer: Recent studies from Indiana University (Rex)	68
--	----

H

Hantavirus pulmonary syndrome in Indiana (Zon, Slama)	216
--	-----

I

Improved results with resection of extensive thoracoabdominal aneurysms (Fehrenbacher, McCreedy, Hormuth, Beckman, Halbrook, Herod, Pittman, Goodson, Siderys)	220
Intraoperative brain mapping during tumor resection from critical areas of the brain (Sartorius)	476

M

Maternal mortality in Indiana: A report of maternal deaths in 1992 (Ragan)	480
--	-----

O

A one-year review of the Eye Injury Registry of Indiana (Harvey, Danis)	406
---	-----

S

Surgical management of atrial fibrillation: The maze procedure (Beckman, Evans, Bandy, Crevey)	144
A survey of mycobacteriology laboratory practice in Indiana (Aszkenasy, Abrams, Karlix, Marrs)	300

FEATURES:

A

The AMA perspective on antitrust reform	130
Americans with Disabilities Act: Are you in compliance? (Carlson)	276
Are you covered in the event of loss? (Blau)	212
Avoiding the 10% early retirement penalty (Blau)	296

C

Case study analysis of physician hospital organizations (Gorey)	364
Choosing a practice management consultant (Cash, Howard)	376

D

The death of Wolfgang Amadeus Mozart (Rold)	464
Digest of health and medical laws: 1994 Indiana General Assembly	290
Doctors, state can be partners in reform (Carlson)	270

F

Four steps for qualified plan distributions (Blau)	140
---	-----

G

Grassroots efforts result in legislative victories (Belch)	200
---	-----

H

- How can you defer mutual fund
taxable income and gains?
(Blau) 24
- How to settle a dispute without going to court
(Sims) 468

I

- ISMA Fifty Year Club 66
- Institutional ethics committees in Indiana:
Organization, structure and function
(Applegate, Finkenbine, Gramelspacher) 370

L

- Licensing board's duty: To protect the public
(Carlson) 452

M

- Managed competition architect explains blueprint
(Carlson) 12
- Managed competition means more
group physician practices
(Erickson, McQuay) 288
- Marble-ous hobby fascinates collector
(Sims) 26
- Members can help ISMA shape health reform
(Lash) 196

N

- The new frontier for physicians: Revenue-focused
(McQuay) 462
- 1993 ISMA convention coverage 34
- 1993 ISMA convention highlights 28
- 1994 annual convention & exposition 380

O

- Oral paging in a community hospital:
Is it used effectively?
(Caldemeyer, Dowell) 208

P

- Peer review shifts focus to patterns of care
(Carlson) 458
- Physical fitness suits doctor to a "tee"
(Sims) 214
- PHOs and POs: Should you take the plunge?
(Carlson) 18
- Physician serves as advocate for abused
(Sims) 378
- Physician stitches award-winning quilts
(Sims) 142

- Practice parameters improve patient care
(Carlson) 188
- Public opinion on tobacco use, its
taxes and public policy
(Torabi, McAllister, Kotecki) 134

S

- Stark outlook for physician self-referral
(Tabler, Haycox) 360
- Strategic planning: Proactively shaping your future
(McCaslin) 202

T

- Tax planning for college
(Blau) 470
- Telemedicine changing practice of medicine
(Carlson) 352
- The 10 most important clauses in
a managed care contract
(Mowery) 284

W

- What computers can do for you
(Carlson) 122
- Will there be a doctor in the House?
(Carlson) 116
- Wishard plaque honors pioneer hip surgeon
(Kernek) 298
- Women urged to play role in organized medicine
(Carlson) 346

DEPARTMENTS:

- Annual reports 41, 388
- Alliance report 88, 161, 242, 320, 426, 498
- Commentary 110, 112, 450
- CME awards 98, 174, 254, 330, 436, 508
- CME calendar 92, 164, 246, 324, 428, 502
- Drug names 377, 463
- Editorial 8
- From the museum 90, 162, 244, 322, 500
- Guest editorial 186
- ISMA leadership 67, 170, 250, 326, 430
- ISMA membership report 224
- Letter to editor 6, 268, 344, 448
- News briefs 94, 166, 248, 434, 504
- Obituaries 96, 172, 252, 328, 432, 506
- People 98, 174, 254, 330, 436, 508
- Resolutions 47, 400
- Scientific editorial 114
- Statement of ownership, management
and circulation 499
- Stethoscope 4, 108, 184, 266, 342, 446

AUTHORS:

A

Abrams, Mary Ann Sprauer	300
Applegate, Margaret H.	370
Aszkenasy, O.M.	300

B

Bandy, Maria	144
Beckman, Daniel J.	144, 220
Belch, Lou	200
Blau, Joel M.	24, 140, 212, 296, 470

C

Caldemeyer, Cortland	208
Carlson, Bob	12, 18, 116, 122, 188, 270, 276, 346, 352, 452, 458
Cash, Sally	376
Crevey, Barry	144

D

Danis, Ronald P.	406
Dowell, Anthony R.	208

E

Erickson, Thomas C.	288
Evans, Maria	144

F

Fehrenbacher, John W.	220
Finkenbine, Ryan	370

G

Goodson, Spencer	220
Gorey, Thomas M.	364
Gramelspacher, Gregory	370

H

Halbrook, Harold G.	220
Harvey, William L.F.	406
Haycox, Rolanda Moore	360
Herod, Gilbert T.	220
Hormuth, David A.	220
Howard, Kim	376

K

Karlix, Mike	300
Kernek, Clyde B.	298
Kotecki, Jerome E.	134

L

Lash, Adele	196
-------------------	-----

M

McAllister, Larry	134
McCaslin, Michael J.	202
McCready, Robert A.	220
McQuay, Kameron H.	288, 462
Marrs, Mary	300
Mowery, Nathan R.	284

P

Pittman, John N.	220
-----------------------	-----

R

Ragan, William D.	480
Rex, Douglas K.	68
Rold, Robert L.	464

S

Sartorius, Carl J.	476
Siderys, Harry	220
Sims, Tina	26, 142, 214, 378, 468
Slama, Thomas G.	216

T

Tabler Jr., Norman G.	360
Torabi, Mohammed R.	134

Z

Zon, Robin T.	216
--------------------	-----

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Intraoperative brain mapping during tumor resection from critical areas of the brain

Carl J. Sartorius, M.D.
Indianapolis

Intraoperative brain mapping is an important new surgical adjunct that allows identification and preservation of critical areas of the brain through intraoperative monitoring, seizure mapping and direct cortical stimulation in an awake patient during craniotomy.¹ This allows a safer maximal tumor

resection with minimized neurologic morbidity. The following case is presented.

Case report

A 30-year-old right-handed white man was followed for more than one year with a biopsy-proven low-grade astrocytoma of the language and face motor cortex of the left cerebral hemisphere. He was referred for definitive treatment when this lesion showed

progressive enlargement. He had suffered several grand mal and focal motor seizures, progressive facial weakness and numbness and occasional word finding difficulty. Multiple anticonvulsants had been tried without complete seizure control. His scans (*Figures 1 and 2*) showed a large lesion occupying the left face motor and language region, anterior to the central sulcus.

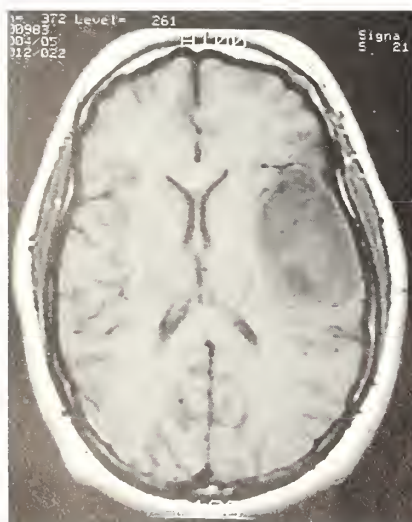


Figure 1: Magnetic resonance imaging (MRI) of the brain. T-1 weighted image axial section. This scan shows the large astrocytoma involving the left face motor cortex and classic language area.

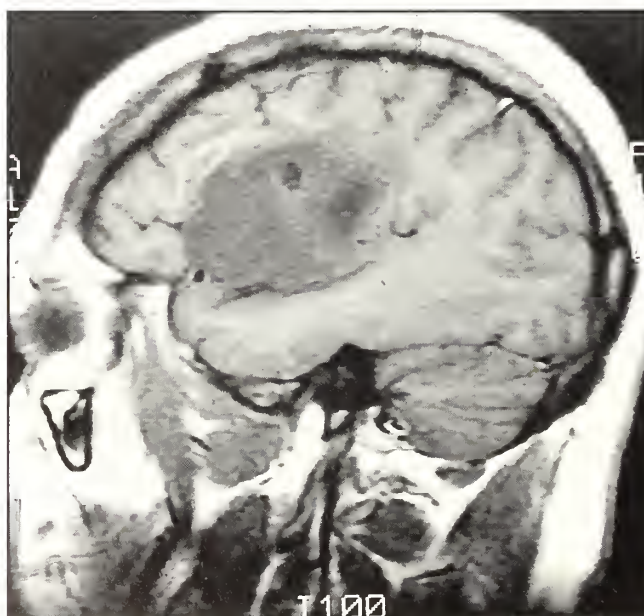


Figure 2: MRI scan of the brain. T-1 weighted parasagittal section. This scan shows the lesion as it relates to the surface sulcal pattern, using the orientation seen by the surgeon during surgery (see *Figure 3*).

Hospitalization and surgery

He underwent a left frontoparietal craniotomy under local anesthetic (Figure 3) with sedation to allow mapping of motor/sensory and language cortex, followed by gross total tumor resection. The motor and sensory areas were identified by direct evoked potential recording and direct brain stimulation. Language areas were identified using stimulation evoked speech arrest and evoked errors in object naming as a marker for language cortex. His epileptogenic foci were mapped during surgery. A "silent area" of cortex between the language areas and face motor area was identified (see blank markers in Figure 4), and the tumor was totally resected through this silent cortical area.

Postoperatively, he had temporary right facial and hand weakness and dysphasia, which improved by the time of discharge. All of his neurologic deficits completely resolved within the first month, and he is back at work, neurologically normal and seizure-free while remaining on anticonvulsants. Postoperative scans have shown no tumor recurrence.

Discussion

Brain tumors often occur in critical areas of the brain, making resection using standard neurosurgical techniques carry potentially greater risk of significant permanent neurological damage. Intraoperative functional brain mapping is a surgical adjunct that allows greater safety during resection of structural lesions in or around critical areas of the brain responsible for movement, sensation and language. Mapping involves direct recording of evoked potentials for identification

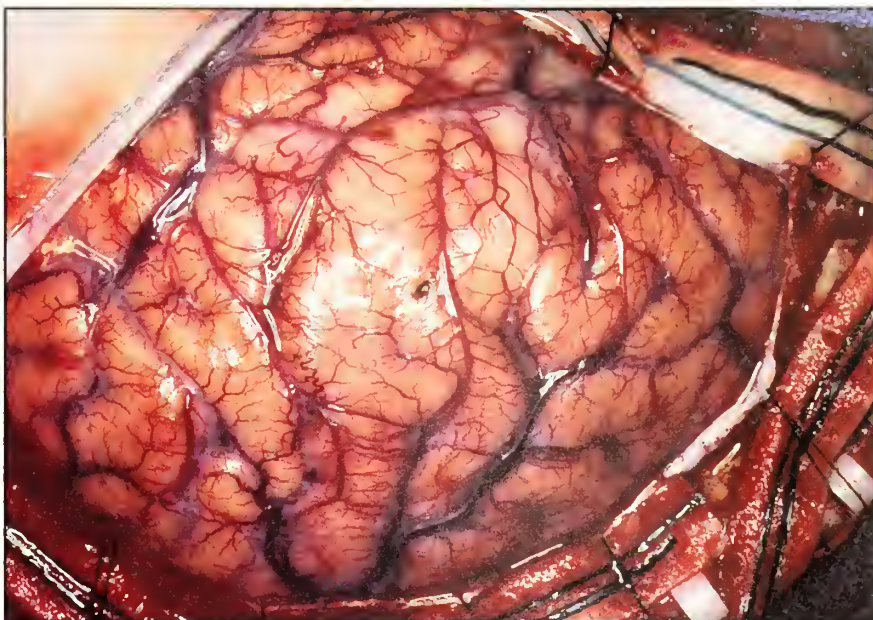


Figure 3: Intraoperative photograph of the left hemisphere before mapping. For orientation, temporal is above, the midline is below, frontal is to the right and parietal is to the left. This picture shows a large area of cortical swelling and abnormal discoloration. Same orientation as Figure 2.



Figure 4: Intraoperative photograph of brain map. Note the blank markers between the face motor cortex and areas of stimulation evoked speech arrest indicating a "window" through which the tumor was approached and completely resected. Legend: T = tongue sensory area; L = lip sensory area; N = solitary or single-naming error; SA = speech arrest; E = epileptogenic foci; DYS = dysarthria - stimulation evoked; P = pharyngeal motor or sensory area; A = anterior aspect of tumor; S = superior aspect of tumor; black thread = overlies central sulcus of Rolando; blank = no function elicited through stimulation.

of the central sulcus of Rolando, electrocorticography, stimulation of motor/sensory cortex to map the motor and sensory homunculus and cortical stimulation to identify language cortex.^{2,3} The important representation contained in these cortical areas is not obvious during visual inspection of the cortex at the time of surgery. Also, movement, sensation and language representation commonly exist away from hemispheric areas that classically contain these functions.³ Mapping allows identification of these important areas. During resection of structural lesions, subcortical mapping with stimulation may be done to allow greater preservation of important structures than would otherwise be possible by direct inspection and standard resection techniques alone. Thus, mapping allows identification and preservation of neurons essential for movement, language and sensation.

During surgery, identified critical areas may be avoided during the tumor exposure, and during tumor removal, preservation of these identified areas allows a maximal tumor resection while minimizing morbidity. This technique allows operation directly within the critical areas of

the brain, encouraging rather than prohibiting a maximal tumor resection with increased safety. This technique may be applied to low- or high-grade circumscribed or infiltrative lesions of the brain. The goal of any resection of an infiltrative glioma is maximal tumor resection with maximal preservation of neurologic function.

Brain mapping often involves craniotomy under local anesthetic with intravenous sedation. This technique is typically well-tolerated by patients after extensive preoperative education and constant intraoperative supervision and assistance. Postoperative transient neurologic deficits are common due to the close proximity of the resection margin to important structures. These deficits typically resolve within a few weeks of surgery. Mapping also allows resection of epileptogenic foci at the time of surgery, when cortical areas responsible for seizures are located in nonessential resectable cortex.

Conclusion

Intraoperative functional brain mapping is an important surgical adjunct that allows identification and preservation of eloquent areas of the brain essential for move-

ment, sensation and language. This technique is useful during resection of cortical epileptogenic regions or structural lesions of either cerebral hemisphere, particularly when these structural lesions involve the critical essential areas of the brain. Mapping allows maximal resection with minimal neurologic morbidity. □

The author thanks Christopher Melin, M.D., and Christopher Rocco, M.D., for their input and assistance during this case.

Correspondence: Carl J. Sartorius, M.D., Indianapolis Neurosurgical Group, 8402 Harcourt Road, Suite 226, Indianapolis, IN 46260.

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Maternal mortality in Indiana: A report of maternal deaths in 1992

William D. Ragan, M.D.
Indianapolis

This is the annual report of the Indiana Maternal Mortality Study Committee. In 1992, Indiana reported five pregnancy-related deaths and 84,058 live births. This gives the state a pregnancy related death ratio of 5.9 per 100,000 live births for 1992. Correcting for one non-obstetric death (Case 821), the maternal mortality ratio for 1992 was 4.7 per 100,000 live births.

The committee met in open session at Ob/Gyn Grand Rounds at the Indiana University Medical Center at 10 a.m. Wednesday, June 2, 1993. The function of the Indiana Maternal Mortality Study Committee was reviewed, and updated statistics were presented. Preliminary data on the 1992 deaths were presented. Haywood Brown, M.D., gave a detailed discussion of amniotic fluid embolism. William Ragan, M.D., gave a brief summary of the recent Indiana experience and maternal mortality in the United States and in developing countries. Cheryl Cowles, M.D., gave first-hand experience concerning maternal mortality in Kenya.

The committee adjourned to the Student Union Building for a closed discussion of the five 1992 deaths. Each case was presented for discussion, establishment of

diagnosis and assignment regarding preventability and responsibility.

The following 1992 deaths were reviewed:

Case 818 – Jan. 27, 1992. A 38-year-old, G4, P1, 36 weeks gestation. Death was considered obstetric and direct. Cause of death was severe preeclampsia.

Case 819 – March 26, 1992. A 29-year-old, G5, P5, nine days post partum. Death was considered obstetric and direct. Cause of death was sepsis.

Case 820 – May 23, 1992. A 24-year-old, G2, P1, 22 weeks gestation. Death was considered obstetric and indirect. Cause of death was myelogenous leukemia.

Case 821 – Aug. 7, 1992. A 12-year-old, G1, P0, 35 weeks gestation. Death was considered non-obstetric. Cause of death was homicide.

Case 822 – Dec. 4, 1992. A 22-year-old, G3, P1, ab1, nine days post partum. Twins. Death was considered obstetric and indirect. Cause of death was possible cardiac arrhythmia.

Discussion

There is a changing trend as to the cause of maternal death. Time-honored causes have been hemorrhage, infection and toxemia. In the United States, emerging causes of maternal deaths are now embolism, cardiomyopathy,

anesthesia complications, adult respiratory distress syndrome (ARDS) and acquired immunodeficiency syndrome (AIDS).¹⁻⁴

The leading cause of maternal death in the United States is pulmonary embolism. Thromboembolism remains an enigma because early recognition and prevention are difficult. Pregnant women are at risk because of the hypercoagulable state associated with pregnancy. Clinical awareness of the signs and symptoms of deep vein thrombosis and prompt initiation of diagnostic and therapeutic measures are the cornerstones of avoiding a life-threatening pulmonary embolus.⁵⁻⁶

There are 10 cases of air embolism in the Indiana maternal mortality files. These often are related to oral/genital sexual activity, and education of antepartum patients would be helpful.⁷ Amniotic fluid embolism is rare, although one of the 1991 deaths (Case 816) was caused by this entity.⁸

ARDS in pregnancy is associated with a maternal mortality of 44%. The main causes of ARDS in pregnancy are hemorrhage, infection and toxemia.⁹

Because it is projected that AIDS will increase among women, more cases of pregnancy-associated deaths due to this cause will occur.¹⁰

There has been concern that

the rising cesarean section rates in the United States might result in an increase in maternal mortality, but at least one article has shown that the risk of maternal death from cesarean section is low.¹¹

In a recent report, trauma was listed as a leading cause of non-obstetric maternal death. Mechanisms of injury in traumatic maternal death include gunshot wounds, motor vehicle crashes, stab wounds, strangulation, blunt head injuries, burns, falls, toxic exposure, drowning and iatrogenic injury.¹²⁻¹³

In Indiana, the leading causes of maternal death are now medical complication and pregnancy, hemorrhage, embolism, infection, toxemia and anesthesia.^{8,14} Physician education, increased availability of prenatal care and proper referral may help the pregnant patient avoid a medical complication. Until 1991 (case 817),⁸ maternal death due to ruptured ectopic pregnancy had not occurred in Indiana since 1984. Early diagnosis of this condition is now possible with sensitive pregnancy tests, ultrasound and laparoscopy. Hemorrhage is still responsible for 10% of current maternal mortality.¹⁵ Deaths due to toxemia often represent a lack of prenatal care and can be prevented. A recent article describes mortality due to

the hemolysis, elevated liver enzymes and low platelets (HELLP) syndrome.¹⁶

The American College of Obstetricians and Gynecologists and the Centers for Disease Control (CDC) in Atlanta continue to collect data on maternal deaths by states and districts.¹ The CDC has initiated a pregnancy mortality surveillance study. The U.S. Department of Health and Human Services has set a goal of no more than 3.3 maternal deaths per 100,000 live births by the year 2000.¹⁷ In the United States in 1985, the maternal mortality ratio for all races was 7.8 per 100,000 live births. For white women, the ratio was 5.2; for all other races, it was 18.1. For black women, the ratio was 20.4 per 100,000 live births.

The high maternal mortality rate for non-white women is a problem that must be overcome.¹⁸ Combined efforts by the organizations mentioned above should provide more meaningful statistics to help curtail preventable maternal mortality in the United States. Several recent articles have stated that maternal mortality is one of the great neglected problems of health care in developing countries. Rates are as much as 100 times higher than those in industrialized countries.¹⁹⁻²¹

Pregnancy-related deaths

continue to be underreported. Often, no mention is made on the death certificate that a pregnancy has been involved. In an effort to pick up missed cases, at least one state has instituted a method in which live birth records are matched with death records for women of reproductive age to detect if a woman died within one year of delivery.²² Three years ago a "check box" relating to pregnancy was placed on the Indiana death certificate to help identify missed cases.

Maternal mortality still occurs. While the numbers are small, the members of the Indiana State Maternal Mortality Study Committee believe that it is important to investigate and report these deaths for statistical and educational purposes. According to our records, many of these deaths are preventable or have preventable factors. In addition, there are undoubtedly many "near misses." We must remain vigilant. □

For a complete list of references, write INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252.

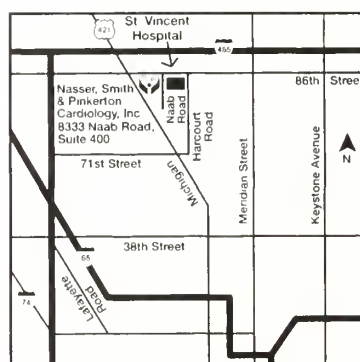
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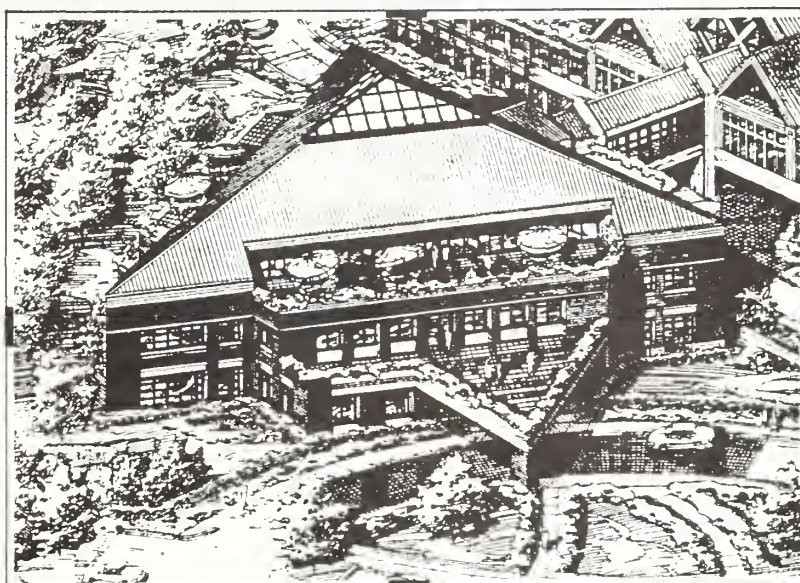
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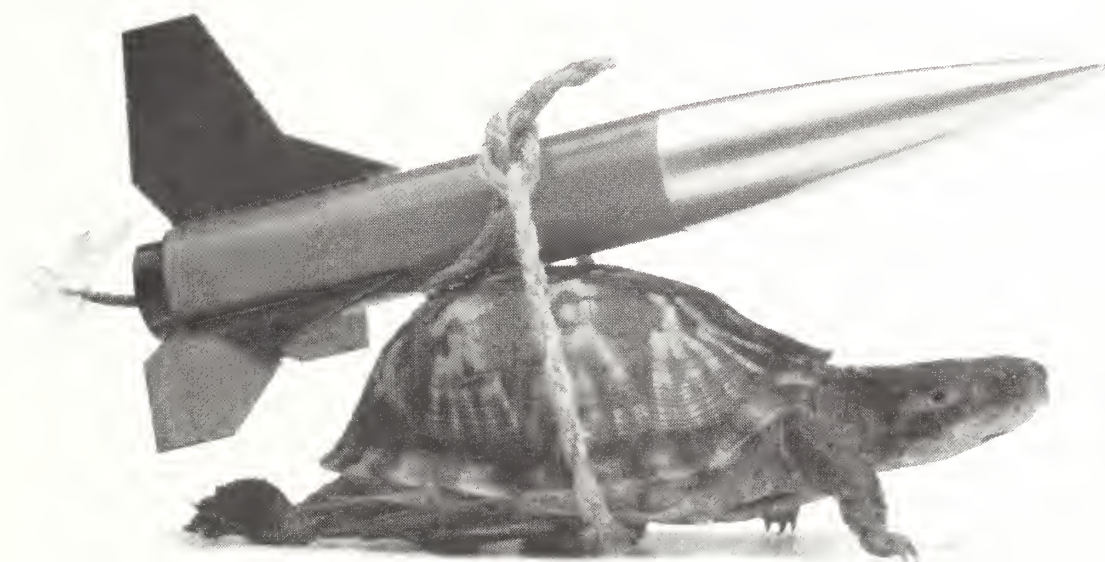
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■alliance report

Darlene Haddawi
ISMA Alliance president

The October celebration of the ISMA Alliance Convention, held in conjunction with the ISMA House of Delegates, marked the successful conclusion of our 18-month transition period from our "auxiliary" past to our "alliance" future. Under the dedicated leadership of Past President Sue Ellen Greenlee and the Alliance Board of Directors, all areas of our alliance organization were evaluated and updated to better serve our membership.

New membership brochures and the ISMA Alliance prospectus are available for counties to use in their membership campaigns. Call Rosanna Iler, 1-800-257-4762, for more information.

The 1994-95 alliance programs will highlight the theme of "Power in Partnership." By working with our county medical societies, each member has the power to make a difference in his/her county through health education programs and projects. The ISMA Alliance, working with the ISMA, increases its power for a stronger voice in health system reform on the local, state and national levels.

1995 calendar

Jan. 25	ISMA/ISMA Alliance Medicine Day, Hyatt Regency, Indianapolis
Jan. 29-31	Confluence II, Chicago
March	Alliance month
March 15	Dues deadline
March 30	Doctor's Day
April 13	Adolescent Health Workshop
May/June	Regional area workshops for county leaders
May 15	AMA-ERF deadlines for AMA Alliance awards
June 18-21	AMA Alliance Annual Convention, Chicago
July 20	State board meeting, Indianapolis
Aug. 15	Resolutions due
Sept. 30	County annual reports due
Oct. 8-10	Confluence I, Chicago
Oct. 19-21	ISMA Alliance Annual Convention, Radisson Hotel, Indianapolis □

Strengthening our partnerships strengthens the "Family of Medicine" and unites our organizations to ensure the continued growth of quality health care in our communities.

1994-95 Executive Board

Darlene Haddawi, president, Bloomington;

Valerie Gates, president-elect, Valparaiso;

Donna Dersch, first vice president, Muncie;

Cheryl Haslitt, central area vice president, Muncie;

Frances Foster, northern area vice president, Fort Wayne;

Patty Lackey, southern area vice president, Evansville;

Phylliss Walker, recording secretary, Bloomington;

Anita Davis, treasurer, Terre Haute;

Hulda Classen, finance secretary, Elkhart; and

Sue Ellen Greenlee, immediate past president, Kendallville. □

1994-95 county presidents

Central area:

Mary Ann Matchett, Delaware/Blackford

Marcia Rice, Indianapolis/Marion

Lynn Brazel, Madison

Lynn Griffin, Tippecanoe

Vickie Flint, Wayne/Union

Northern area:

Cindy Klee, Allen

Judith Van Curen, Elkhart

Raji Rehil, Grant

Deina Abbasi, Howard

Karen Brown, Lake

Donna Serna, La Porte/LaPorte

Jennie Houck, LaPorte/Michigan City

Kara Warrener, Noble/LaGrange

Ann Silberman, Porter

Genelle King, St. Joseph

John Stead, Wells

Southern area:

Laurel Weddle, Bartholomew/Brown

Aggie Matibag, Clark

Charlotte Brubaker, Dubois

Diana Coleman, Floyd

Denise Hendrix, Knox

Carolyn Lindsay & Judy Lawrence,

Monroe/Owen

Shirley Becker, Vanderburgh

Cindy Andreason, Vigo □



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■ from the museum

Oren S. Cooley
Indianapolis

The Indiana Medical History Museum greatly appreciates the artifacts donated each year by health care practitioners throughout Indiana. These artifacts enable the museum to better fulfill its mission of collecting, preserving, exhibiting and interpreting the heritage of the healing arts.

The Indiana Medical History Museum, located in Indianapolis, maintains a collection of more than 15,000 medical and health care artifacts from the 19th and early 20th centuries. The extensive collections include not only medical and surgical instruments but also dental equipment, diagnostic instruments, pharmaceutical bottles, nursing uniforms, homeopathic medicine cabinets, "quack" devices and patent medicine bottles as well.

In addition, the library of the Indiana Medical History Museum has more than 3,000 volumes from the 19th and early 20th centuries that physicians used to further their medical education or to supplement their professional training. Besides these volumes, the museum's collections include photographs, artwork, equipment catalogs, diplomas, certificates, broadsides, medical notebooks, fee bills and the personal papers of various health care professionals.

The museum uses its extensive collections to illustrate the topics presented in the museum's exhibits gallery or to supplement the educational programs presented to school children and community groups. Changing every nine months, the exhibits explore numerous topics that relate to

different aspects of health care – from the development of the medical profession to the public's response historically to sexually transmitted diseases.

Researchers also visit the museum to use the collections to glean information that will provide a better insight into the practice of medicine and the development of health care. Besides relying on the collections as an educational resource, historians and other researchers often photograph or film the collections not only to illustrate papers and publications but also to appear in audio-visual productions and motion pictures.

To give any health care object to the Indiana Medical History Museum, a donor should follow these procedures:

1. Obtain an appraisal of the object(s) for income tax purposes (if desired) before contacting the Indiana Medical History Museum. The museum cannot provide the appraisal necessary to determine the value of the donation.
2. Call (317) 635-7329 to schedule an appointment with the museum's curatorial staff to examine the potential donation. This appointment may occur either at a business, a residence or the museum.
3. Undergo a short interview by the museum's curatorial staff to convey any information of historical significance about the potential donation.
4. Once the museum accepts the object(s), the curatorial staff will send the donor a gift agreement that lists the object(s) included in the donation. Review the gift



The Indiana Medical History Museum uses donated objects, such as these saddlebags, stethoscope and toothkey from the 19th century, to prepare exhibits, create traveling displays and conduct educational programs.

5. Sign and date the gift agreement and return the gift agreement to the museum in the provided envelope.
Afterwards, the donor will receive a copy of the gift agreement. The donor also will receive the museum's newsletter and other materials designed to keep donors informed of the various educational programs the museum offers. ▮

The author is director of the Indiana Medical History Museum.

ARNETT CLINIC

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In eight outpatient facilities, over 110 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The majority of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 320,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Managed Health Plans and the corporate affiliate of Arnett Pharmacy.

Practice Setting

At this time, over 110 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

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Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, life insurance, and continuing education funds.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. Money Magazine identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

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about Arnett Clinic and physician employment opportunities contact:

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Lafayette, IN 47904 (317) 448-8000
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Lafayette, Indiana

■ cme calendar

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will present the "12th Annual Update in Cardiology" at the Radisson Plaza Hotel in Indianapolis Dec. 2.

For registration information, call Beth Hartauer, (317) 338-3460.

Rush Medical College

Rush Medical College in Chicago will present "Neurology for the Non-Neurologist" Dec. 7 through 9 at the Swissotel in Chicago.

For registration information, call the Rush-Presbyterian-St. Luke's Medical Center at (312) 942-7095.

JCAHO seminar

The Joint Commission on Accreditation of Healthcare Organizations will sponsor a seminar for physicians interested in expanding performance improvement activities to include outcomes measurement. "Tools & Techniques for Improving Clinical Outcomes: A Practical Seminar for Physicians & Clinical Leaders" will be held

Nov. 29 and 30 in St. Louis and Dec. 8 and 9 in Cincinnati.

The seminar will help physicians develop and implement guidelines and paths as a strategy to effective resource utilization and outcome measurement. Sessions will be conducted by a physician and nurse experienced in integrating guidelines with quality activities.

For more information, call the Joint Commission Customer Service Department, (708) 916-5800. Mention program code 0414.

University of Wisconsin

The University of Wisconsin School of Medicine will present "Clinical Cardiology, 1994" Dec. 27 through 29 at the Marriott World Center in Orlando, Fla.

Primary care physicians, nurses and other health professionals interested in an in-depth cardiology update are invited to attend.

For more information, call Sarah Aslakson, (608) 263-2856.

Ohio State University

Ohio State University Medical Center will present "Leiomyomata: Growth, Symbiosis and Extrication" Dec. 17 in Columbus, Ohio.

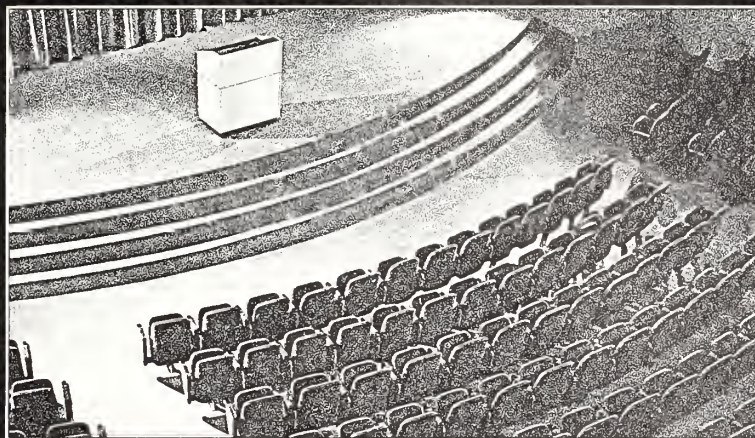
For registration information, call Sandi Latimer, (614) 293-3660.

University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Mar. 15-17-** A Symposium in Diabetes Care.
- Mar. 30-31-** Challenges and Changes in Obstetrics and Gynecology.
- Apr. 1** - Transvaginal Ultrasound Workshop.
- Apr. 5-7** - Ultrasound in Obstetrics and Gynecology.

These courses will be held in the Towsley Center in Ann Arbor, Mich. For registration information, call Vivian Woods at (313) 763-1400. □



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■ news briefs

IU affiliates with two Indiana hospitals

Indiana University Medical Center (IUMC) in Indianapolis has announced affiliation agreements with two Indiana hospitals.

Bloomington Hospital and IUMC formed a partnership designed to enhance and expand the clinical programs, the graduate and undergraduate medical education programs and managed care contracting at both institutions. In addition, the agreement is intended to open the way for the integration of hospital systems that would benefit both institutions.

The agreement between Union Hospital in Terre Haute and IUMC creates a collaboration in which IUMC can broaden its primary care base, and Union Hospital can enhance its clinical and educational programs. The affiliation will result in the development of IUMC medical student clerkships and medical resident rotations at Union Hospital as well as the enhancement of continuing medical education programs.

Riley opens new unit for cancer patients

Riley Hospital at the IUMC has opened a new center designed to accommodate the special needs of children undergoing chemotherapy and bone marrow transplantation. The Riley Children's Cancer Center, Richard E. and Pauline Klingler Special Care Unit is located on the fifth floor of Riley Hospital.

The new unit includes 28 beds, with nine of the beds dedicated to a pediatric transplant program. It also includes an apheresis program to supply stem cells used to treat children with blood diseases and others who undergo bone marrow transplantation. The unit

is the first in Riley Hospital for children who suffer from similar illnesses. Until now, children have been hospitalized on age-specific units.

Joint Commission gets CLIA 'deemed' status

Clinical laboratories accredited by the Joint Commission on Accreditation of Healthcare Organizations will be "deemed" to meet the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

Beginning Jan. 1, 1995, the Joint Commission will conduct surveys for CLIA certification in both freestanding laboratories (those not associated with an accredited hospital or other health care organization) and laboratories affiliated with such organizations.

For more information about the accreditation and CLIA certification, call Anne Belanger, director, laboratory evaluation, (708) 916-5783. To request an application for a clinical laboratory survey, call the organizational liaison department, (708) 916-5410.

Statement on ovarian cancer available from NIH

A National Institutes of Health (NIH) consensus development statement on ovarian cancer is available from the NIH Office of Medical Applications of Research. Prepared by a panel of experts who considered scientific evidence presented at a consensus development conference at NIH, the report contains recommendations and conclusions about ovarian cancer.

Free, single copies of the statement may be obtained by contacting William H. Hall, Director of Communications, Office of Medical Applications of Research, National Institutes of

Health, Federal Building, Room 618, Bethesda, MD 20892, (301) 496-1143.

COLA begins toll-free number service

The Commission on Office Laboratory Accreditation (COLA) has a new toll-free customer service number, 1-800-298-8044. All participants in COLA and others who have questions about the program may use the number.

COLA is a voluntary nonprofit accreditation and education program for physician office laboratories.

Medical technologists who staff the toll-free line are available to answer questions about Clinical Laboratory Improvement Amendments (CLIA) and other lab-related issues.

Free booklet explains health care expenses

The American Medical Association and VISA have teamed up to offer a free consumer booklet to educate patients on health care expenses.

Titled *Answers to Your Important Health Care Questions*, the booklet covers general health education information and emphasizes the need to plan for health care expenses. It answers questions such as "What's the best way for me to pay my medical bills?" and "What is a deductible and what is a co-payment?" The booklet also addresses some clinical concerns of patients, such as the difference between a chronic and an acute medical condition, what to tell a physician about the medications they are taking and what to consider before substituting a generic drug for a brand one.

Physicians may order the booklet by calling the AMA, 1-800-262-3211, ext. 4507. □

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Send CV to J. Edward Greene MD, medical director, Bethesda Group Practice, Inc., 619 Oak St., Cincinnati, OH, 45206, or contact Mary Lah, administrative director, (513) 569-5435.

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■ obituaries

Richard S. Griffith, M.D.

Dr. Griffith, 74, a retired infectious disease specialist in Indianapolis, died Aug. 12, 1994.

He was a 1944 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Griffith worked at Eli Lilly & Co. for 37 years, retiring in 1983 as clinical research consultant at Lilly Research Laboratory at Wishard Memorial Hospital. He was a professor emeritus of medicine at Indiana University.

Harold D. Lynch, M.D.

Dr. Lynch, 93, a pediatrician in Evansville for 30 years, died July 1, 1994, at Meadowood Retirement Community in Bloomington.

He was a 1926 graduate of the Indiana University School of Medicine.

Dr. Lynch was one of the first pediatricians in southwestern Indiana and was a staff member at Deaconess and Welborn Baptist hospitals and St. Mary's Medical Center. He was on the board of

managers of Boehne Tuberculosis Hospital in Evansville and on the Evansville-Vanderburgh County Health Department Board from 1952 to 1955. He was associate medical director of Mead Johnson Laboratories from 1961 to 1966. Dr. Lynch served on the editorial board of *INDIANA MEDICINE* from 1953 to 1967 and wrote articles on child nutrition for several medical periodicals. He wrote a popular book titled *Your Child Is What He Eats*. He was a fellow of the American Academy of Pediatrics and of the American College of Physicians and a diplomate of the American Board of Pediatrics. In 1954, he served as president of the Indiana State Pediatric Society.

George G. Morrison, M.D.

Dr. Morrison, 65, a Lawrenceburg family physician, died Sept. 4, 1994, in Brookville.

He was a 1955 graduate of the Indiana University School of Medicine and served two years in the Air Force Medical Corps in Lubbock, Texas.

Dr. Morrison came to Lawrenceburg in 1958. He served three terms as chief of staff at Dearborn County Hospital, where he helped establish the first intensive care unit. He was a member of Alpha Omega Alpha, a national medical honorary association. Dr. Morrison was a member of the county's first community mental health board and served on the Lawrenceburg Community Schools Board from 1974 to 1982.

John E. Schreiner, M.D.

Dr. Schreiner, 73, a retired Bremen family practitioner, died Aug. 13, 1994, at the Community Hospital of Bremen.

He was a 1945 graduate of the Indiana University School of Medicine.

Dr. Schreiner had lived in Bremen since 1948, where he had been a family physician for 38 years. He served one term as coroner of Marshall County. He was a member of the Jaycees and the Kiwanis Club. □



Survival lessons from the Alamo.

Interactions

Medical Staff Leadership Conference — January 13-15, San Antonio, Texas

Health system reform might seem like a never-ending battle, but with leadership, vision, and perseverance, you and your medical staff can overcome any obstacle. Learn what it takes to succeed in today's rapidly changing environment. Come to *Interactions* in beautiful San Antonio, Texas, January 13-15.

Experience a new way of thinking about the future.

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- Resource allocation
- Regulatory constraints

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Special emphasis will also be placed on developing and refining your strategic planning, team building, and com-

munication skills. Each participant will learn how to be a more effective arbitrator, facilitator, manager, negotiator, problem solver, and peacemaker.

Your team leaders.

Sponsored by the *American Medical Association*, in cooperation with the *National Association Medical Staff Services* and the *Texas Medical Association*, this conference features well known experts from the health care field.

Who should attend.

The curriculum is designed to benefit experienced and newly elected or appointed medical staff leaders, including: chiefs of staff, department chairs, vice presidents of medical affairs, medical staff committee chairs, and medical staff services professionals.* Bring a team from your hospital!

For more information or to register, call 800 621-8335.

*The AMA designates the *Interactions* conference for 18 credit hours of Category 1 of the Physician's Recognition Award of the AMA.

American Medical Association

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Dr. Jay L. Grosfeld, Lafayette Page Professor of Surgery and chairman of the department of surgery at Indiana University Medical Center, was named editor-in-chief of the *Journal of Pediatric Surgery*. The offices of the journal, published by W.B. Saunders, will move to Indianapolis from Los Angeles.

Dr. Thomas J. Linnemeier of Northside Cardiology in Indianapolis participated in filming a training video entitled "Rapid Exchange Catheters" produced for Advanced Cardiovascular Systems.

Dr. Hill Hastings II of the Indiana Hand Center in Indianapolis was the course chairman for the AO/ASIF Advanced Hand Symposium held in Telluride, Colo. He spoke on "Mesh Plate-P1 Fracture" and "Vascularized Distal Radius Grafts" and was the moderator for a panel on "Combined Injuries."

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke on nasal implants and grafts update at the eighth annual symposium on the Latest Advances in Cosmetic Surgery of the Face, held in Newport Beach, Calif., and sponsored by the American Academy of Facial Plastic and Reconstructive Surgery.

Dr. Steven F. Isenberg, an Indianapolis otorhinolaryngologist, has had an article titled "Cystic Hygroma: Recurrence in an Adult Thirty-Four Years Later" accepted by the *American Journal of Otolaryngology*.

Dr. Robert D. Yee, chairman of the department of ophthalmology at Indiana University Medical Center, has received a grant of \$100,000 from Research to Prevent Blindness to support research into

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

July

Arregui, Maurice E., Indianapolis
Bosley, Roger E., Lafayette
Green, Scott A., Anderson
Hochstetler, Mark A., Fort Wayne
Johnson, David W., Evansville
Lehmann, Juergen J., Fort Wayne
Manley, Clovis E., Evansville
Reitz, Lawrence A., Zionsville
Slack, John D., Indianapolis

August

Abeleda, Lamberto V., Shelbyville
Cristea, Richard L., Munster
Duerden, Marc E., Indianapolis
Harvey, William D., Logansport
Hilburn, Jeffrey W., Indianapolis
Kim, Charles Y., Terre Haute
Lee, Truman H., Indianapolis
Mohr, William H., Kokomo
Sklenarz, Krystyna M., Merrillville
Tribbett, Charles R., Monticello
Watson, Leo G., Kokomo
Yessenow, Randall S., Merrillville

the causes, treatment and prevention of blinding diseases.

Dr. Brett Graham, a family physician, has joined the medical staff at Methodist Hospital in Indianapolis.

Dr. Frederick B. Stehman, chief of obstetrics and gynecology at Wishard Memorial Hospital in Indianapolis, has been appointed chairman of the department of obstetrics and gynecology at Indiana University School of Medicine.

Dr. William H. Beeson, an Indianapolis facial plastic and reconstructive surgeon, gave six lectures at the Foundation for Facial Plastic Surgery conference in Newport Beach, Calif. He spoke on "Rhytidectomy - Current Trends and Analysis of 2,000 Cases," "Positioning Your Practice for Health Reform," "Establishing an Ambulatory Surgery Center," "Laser Skin Resurfacing," "Laser

Abrasion and Chemexfoliation in Facial Surgery," and "Still a Role for Phenol?" Dr. Beeson's research article on "Carbon Dioxide Laser Blepharoplasty: A Comparison to Electrosurgery" was published in the June issue of the *International Journal of Aesthetic and Restorative Surgery*.

Dr. Maurice Arregui, an Indianapolis surgeon, served as program moderator for the session on laparoscopic hernia held during the Fourth World Congress on Endoscopic Surgery in Kyoto, Japan. He also presented papers on "Diagnosis of Ampullary Adenoma with Laparoscopic Duct Exploration and ERCP" and "A Comparison of Intraoperative Ultrasound vs. Cholangiography in Evaluation of Common Bile Duct During Laparoscopic Cholecystectomy." In addition, he spoke on "Basic Technique for Laparoscopic Inguinal Hernia

Repair" and "An Overview of Laparoscopic Management of Complex Pancreatico-Biliary Problems in the U.S." to surgeons in Matsuyama, Japan. Dr. Arregui and his associate, **Dr. Robert F. Nagan**, recently wrote a book titled *Inguinal Hernia: Advances or Controversies?* that was published by Radcliffe Medical Press Ltd. of Oxford, England.

Dr. Worthe S. Holt Jr. was named associate director of the family practice residency program at St. Francis Hospital in Beech Grove. He was previously affiliated with the family practice residency program at Indiana University Medical Center.

Dr. William Nasser of Nasser, Smith & Pinkerton Cardiology in Indianapolis spoke on "Tertiary / Regional Partnering" at the third annual International Heart Conference in Las Vegas.

Dr. Nancy Branyas of Nasser, Smith & Pinkerton Cardiology in Indianapolis appeared twice on "27 Alive" on cable Channel 27. She spoke on hypertension and on palpitations and treatment.

Dr. Paul Honan, a Lebanon, Ind., ophthalmologist, has been recognized by the American Academy of Ophthalmology as a Senior Honor Award recipient. The award recognizes an individual who has made a significant contribution to ophthalmology through presentations at the academy annual meeting and who has served on academy committees.

Dr. James A. Rang, an Evansville orthopaedic surgeon, was elected president of the Deaconess Hospital medical staff. Other officers are **Dr. Matthew R. Lee**, a family practitioner, president-elect, and **Dr. Edward P. Daetwyler**, an otolaryngologist, secretary-

treasurer.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was an instructor and panelist at the meetings of the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) and American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) in San Diego, Calif. At the AAO-HNS meeting, he led the Chemical Peel I and II courses and discussed recent developments in the transconjunctival blepharoplasty procedure. At the AAFPRS meeting, he was a panelist for discussions of state-of-the-art chemical peeling techniques and practical, cost-effective applications of the HGM Surgica K-1 krypton laser. He also presented a paper on "Treatment of Perioral Rhytids: Chemical Peel vs. Dermabrasion."

New ISMA members

Scott L. Ackley, M.D., Indianapolis, radiation oncology.

Karl M. Baird, M.D., Richmond, orthopaedic surgery.

Sami M. Baraka, M.D., Winchester, family practice.

Rohit Bawa, M.D., Richmond, otolaryngology.

Edison R. Blanco, M.D., Elkhart, family practice.

Blanca Rosa Clark, M.D., Anderson, family practice.

Daniel J. Cumiskey, M.D., Fort Wayne, orthopaedic surgery.

Phillip M. Dulberger, M.D., Anderson, anesthesiology.

J. Carlos Espinosa, M.D., Roanoke, general surgery.

James M. Esser, M.D., Evansville, vascular interventional radiology.

Helmut Falk Jr., D.O., Franklin, anesthesiology.

James S. Fix, M.D.,

Bloomington, cardiovascular diseases.

Custodio A. Garrido, M.D., Huntington, family practice.

Gene W. Grove Sr., M.D., Elkhart, anesthesiology.

Jonathan D. Hart, M.D., Argos, family practice.

Stephen J. Hornak III, M.D., Richmond, cardiovascular diseases.

Jon M. Igelman, M.D., Richmond, dermatology.

Yung-Ray Jow, M.D., Hobart, anesthesiology.

Brian K. Kohles, M.D., Anderson, family practice.

Walter S. Langheinrich, M.D., South Bend, neurological surgery.

Joseph Lewinbuk, M.D., Valparaiso, psychiatry.

Jana L. Marjenhoff, D.O., Bedford, family practice.

Margaret S. Maxwell, M.D., Indianapolis, family practice.

Thomas F. Mertins, M.D., Warsaw, family practice.

Mitchell D. Meyer, M.D., Kokomo, family practice.

Phillip M. Miller, M.D., Greenfield, family practice.

Dennis L. Newberry III, M.D., Evansville, family practice.

Scott W. Pennington, M.D., Richmond, anesthesiology.

Scott S. Propeck, M.D., Indianapolis, internal medicine.

Eric P. Purdy, M.D., Bluffton, ophthalmology.

William L. Remington, M.D., Warsaw, family practice.

Milton Robinson, M.D., Logansport, psychiatry.

Lindsey R. Rolston, M.D., New Castle, orthopaedic surgery.

Jyotsna P. Sanghvi, M.D., Merrillville, internal medicine.

Nitin S. Sardesai, M.D., Munster, family practice.

Jeffrey J. Segal, M.D., Terre Haute, neurological surgery.

people

Philip A. Serbin, M.D.,
Bedford, urological surgery.

David L. Skidmore, M.D.,
Columbus, anesthesiology.

Diane R. Sommer, M.D.,
Indianapolis, family practice.

Erick Stephanian, M.D., Terre
Haute, neurological surgery.

Mani N. Sury, M.D., Kokomo,
internal medicine.

Ishik C. Tuna, M.D., Evans-
ville, traumatic surgery.

Scott M. Wilhelmus, M.D.,
Bloomington, dermatology.

Shahab Zaidi, M.D., India-
napolis, endocrinology.

Nancy Zinni, M.D., Franklin,
anesthesiology. ▢

Send us your news

INDIANA MEDICINE invites ISMA members to submit news and photos for the "People" section. We will publish short items on physicians' awards, honors, elections and other newsworthy accomplishments. Mail your notices to Tina Sims, Managing Editor, Indiana Medicine, 322 Canal Walk, Indianapolis, IN 46202-3268 or fax them to (317) 261-2076. ▢

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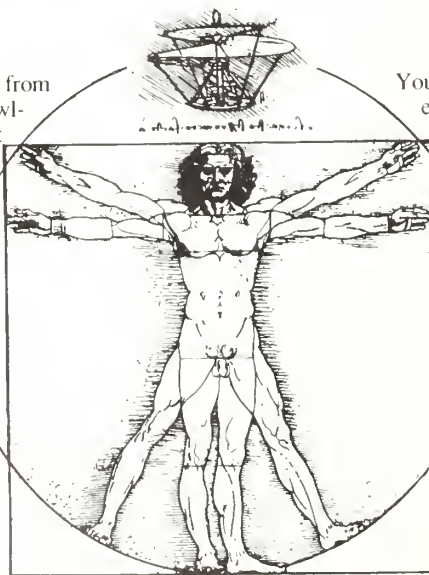
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■ classifieds

RUSH MEMORIAL HOSPITAL anticipates an opening for an emergency room physician in January 1995. Located in Rushville, Ind., 35 miles southeast of Indianapolis, Rush Memorial Hospital serves a county-wide population of 20,000 people. Our E.D. sees approximately 8,500 patients annually. Two 24-hour shifts weekly will become available as of Jan. 1, 1995. Scheduling is flexible, physician salaries are competitive, and malpractice is paid. Direct inquiries to Keith Singer, M.D., Director of Emergency Services, Rush Memorial Hospital, 1300 N. Main St., Rushville, IN 46173, phone (317) 932-4111.

IU DEPARTMENT OF FAMILY MEDICINE is seeking a board-certified family physician for a full-time clinical faculty position. Candidate must have a strong interest in academic medicine and experience in clinical practice. Interest in maintaining an OB practice a definite plus. This individual will participate in the departmental practice plan. IU is an Affirmative Action/Equal Opportunity Employer. Send resumes to D.I. Allen, M.D., Chair, Dept. of Family Medicine, 1110 W. Michigan St., Indianapolis, IN 46202-5102.

MEDICAL PRACTICE FOR SALE - Merrillville, Ind. Price negotiable. Near Southlake Methodist Hospital. Twenty-five year established solo practice. Completely furnished. Call Robert Wolf, M.D., (219) 769-6625.

FOR SALE - Brentwood EKG FCP-15 on table with wheels; Birtcher hypercator Model 733; Goodlite floor exam light; Welch Allyn audioscope with charging stand Model 71123; Schuco Mist Model 5711-100; Graham field C-ray light; glass containers; fetal Dopplers; fetascopes; Circumstraint/pa-poose board; Mayo table on wheels; infant scale; Sears Correct-o-sphere 2 typewriter; Reflotron laboratory analyzer; autoclave; centrifuges for blood and urine;

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IMMEDIATE OPENING for BC/BE family practitioner with ER experience to staff hospital-based, fast track/express care center located withn St. Vincent Hospital ED, Indianapolis. Full benefits, including occurrence malpractice, health and disability insurance, fees and dues paid, paid vacation, CME allowance and participation in pension plan, are offered. Please send CV to Dr. Susan Stephens, 11011 Ditch Road, Carmel, IN 46032, (317) 844-9640.

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community, many recreational opportunities, 50 miles from Chicago. Six weeks per year PGE and vacation. Early full partnership. Send CV and cover letter to Drs. Covey and Marquez, South Ridge Pediatric Center, P.C., Suite 3, 2101 Corneford Road, Valparaiso, IN 46383.

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Advertising index

AdminaStar	497
Arnett Clinic	501
Auto Purchasing Unlimited	514
Bethesda Group Practice	505
Cancer Treatment Centers	479
Central Pharmaceuticals	445
Custom Creations	451
ISMA Insurance Agency	449, Covers
James Cancer Hospital	471
Medical Protective	505
The Money Store	475
Palisades Pharmaceuticals	444
Physicians' Directory	482
Physicians Insurance Co. of Indiana	Cover
Reeves Hummer	447
U.S. Air Force	510
University Place	503
Veterans Administration Medical Center	514

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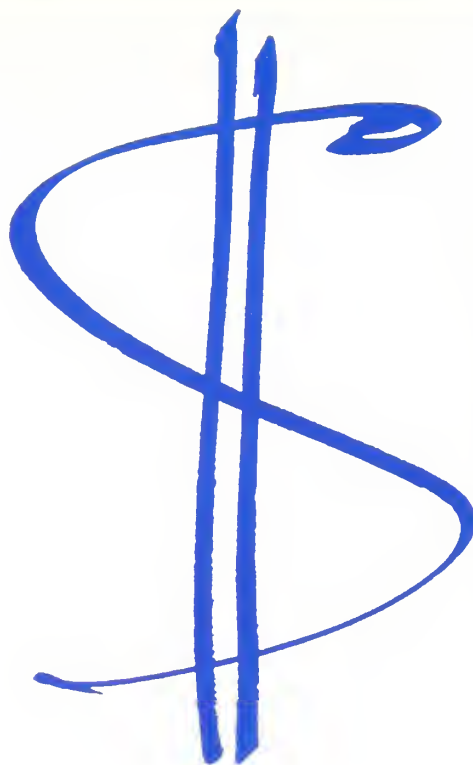
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Contact your ISMA Benefit Representative at 1-800-442-ISMA

ISMA Members And Their Employees:

STACK YOUR CURRENT MEDICAL COVERAGE UP AGAINST THESE HIGH QUALITY, LOW-COST PLANS.

These medical plans have been specially designed for ISMA members and their employees to provide the highest quality coverage at the lowest possible cost. And, there is a special Claims Paying Unit for processing ISMA claims, with access through toll-free WATS lines. So take a look at the many plan options below and judge for yourself how your current coverage stacks up.

COMPREHENSIVE MAJOR MEDICAL PROTECTION

		\$1 Million Organ or Tissue Transplant Benefit	\$2 Million Major Medical Maximum Benefit	PCS Prescription Drug Card	Incentivized Benefits when PPN providers utilized
250	<ul style="list-style-type: none"> \$250 calendar year deductible, \$500 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓	✓	
500	<ul style="list-style-type: none"> \$500 calendar year deductible, \$1,000 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		
1,000	<ul style="list-style-type: none"> \$1,000 calendar year deductible, \$2,000 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		
2,000	<ul style="list-style-type: none"> \$2,000 calendar year deductible, \$6,000 per family Stop-Loss limit \$10,000 per person, \$30,000 per family 	✓	✓		
250PPN	<ul style="list-style-type: none"> \$250 calendar year deductible, \$500 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓	✓	✓
500PPN	<ul style="list-style-type: none"> \$250 calendar year deductible, \$500 per family Stop-Loss limit \$5,000 per person, \$10,000 per family 	✓	✓		✓

MEDICARE SUPPLEMENT

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days of In-Hospital Medical Care
- 100% Usual, Customary, Reasonable allowances for surgery, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- \$1 Million Organ or Tissue Transplant Benefit
- \$2 Million Major Medical Benefits (\$100 calendar year deductible)

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

DENTAL PLAN

- Usual, Customary and Reasonable allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- Routine dental care paid at 80%
- Major dental care paid at 50%, following one year participation in the plan
- Orthodontia paid at 50%, following one year participation in the plan with \$1,000 lifetime maximum benefit per person
- \$1,500 maximum dental benefit per person per calendar year



Available through the
ISMA Insurance Agency.

For more information regarding these coverages contact:

Central Indiana Earl Williams 317-595-6520 800-421-3020/Jerry Jacobson 317-255-1781

North Central Indiana Jim Brennan, Jr. 219-258-0557

North West Indiana Ross MacLennan 219-769-6933 219-462-8066

ISMA Headquarters Thomas Martens 317-261-2060 800-257-4762

Blue Cross and Blue Shield of Indiana, underwritten by Associated Insurance Companies of Indiana, Inc., provides the medical and dental insurance plans through Acordia Health Industry Services, Inc. Associated Insurance Companies, Inc., is a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.



